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WAUKESHA, WISCONSIN

STUDIES IN THE AVITAMINOSES

This page is the first of a series on vitamin deficiencies presented by the research division of The Upjohn Company, not merely because of the profession's widespread interest in the subject, but also because of the service which these reproductions might render toward earlier recognition of vitamin deficiency states.

The Cutaneous Manifestations of Vitamin A Deficiency

Goosepimple-like papules, occasionally seen in vitamin A deficiency, occur most frequently on thighs and arms, but may appear anywhere on the skin. More common than the acneform eruption.

Acneform papules of vitamin A deficiency. Pustulation is rare, but crusts and scales may be observed. Dryness of involved skin precedes both types of lesions.

Although the classic manifestations of vitamin A deficiency are familiar to every physician, many of these represent late stages of deprivation. In some cases, cutaneous changes may provide an opportunity for earlier recognition. These cutaneous changes, when fully developed, consist of two distinct types of eruptions—a goosepimple-like papule and an acneform lesion in which pustulation rarely occurs. The absence of perspiration is due to atrophy of the sweat glands and keratinizing metaplasia of the ducts. The papular cornified lesions are due to the keratinization of the sebaceous glands and hair follicles. In some subjects, accentuation in pigmentation due to an increase in melanin and melanin-building pigments is observed. Unlike the ocular manifestations of vitamin A deficiency, the skin lesions respond slowly to specific therapy, requiring from 4 to 12 weeks for their eradication.

• •

A two-page insert, presenting full-color reproductions of vitamin A deficiency lesions, and so organized that it may be easily retained for future reference, appears in the January 20 issue of the Journal of the American Medical Association.

UPJOHN

THE WISCONSIN MEDICAL JOURNAL

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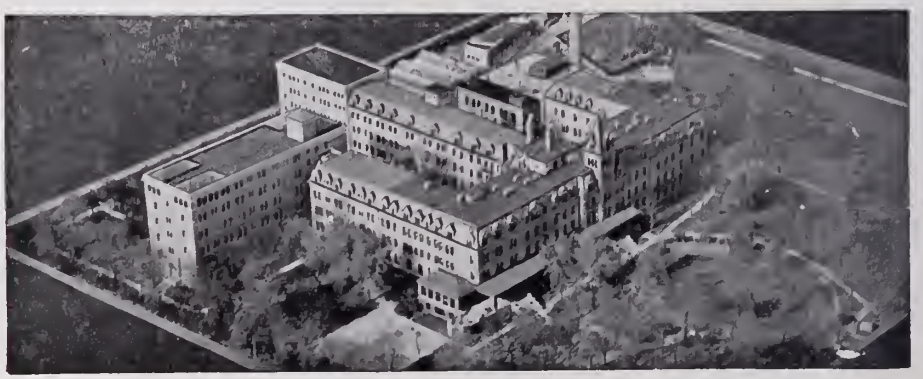

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METHODS FOR QUANTITATIVE ESTIMATION OF THE VITAMINS

IV. Measurement of Vitamin B_1 Activity

● The existence of the factor now known as vitamin B_1 was first established by the work of Eijkmann over four decades ago. In 1912, Funk (1) isolated a nitrogenous substance—capable of curing polyneuritis—to which he applied the provisional name of "beri-beri vitamine." Vitamin B_1, therefore, is the first of the essential food factors to be termed a vitamin.

Despite this fact, it has only been within recent years that specific biologic methods for estimation of this vitamin—free from the serious limitations of the earlier assay methods—have become available. Many of the earlier techniques were proposed before resolution of the "vitamin B complex" into its component factors. In addition, only within the past few years have reference standards of vitamin B_1 activity—the standard absorption product and thiamin—become generally and conveniently available for use in the quantitative determination of vitamin B_1.

As indicated in a recent review (2), modern bioassay methods for vitamin B_1 are quite diverse in detail. It is hoped that identification of this dietary essential (3) will soon bring a dependable chemical method for its estimation which will permit more extensive and reliable investigation of the vitamin B_1 activities of foods than has heretofore been possible. Recent advances in the science of nutrition, however, have brought definite refinement and improvement of modern bioassay methods for determination of the antineuritic factor.

In illustration, quite recently a rat curative technique employing crystalline thiamin chloride as the Reference Standard was endorsed by the U. S. P. Vitamin Advisory Board (4), for use in determining the vitamin B_1 activities of foods or other biological materials which contain a sufficiently high concentration of the vitamin. In this method young rats (not exceeding 50 grams in weight or 30 days of age) are maintained on a specified vitamin B_1-deficient diet until their body stores of the vitamin are depleted as judged by the onset of acute polyneuritis. Such depleted animals are suitable for use in the assay proper provided the depletion period required for the development of acute polyneuritis has not exceeded 75 days.

To each properly prepared animal is administered a single dose of the reference standard of such size that a curative period of not less than 5 or more than 15 days will be produced. Each animal is then carefully observed until the exact degree of acute polyneuritis reappears, at which time an appropriate single dose of the material under assay is administered. The duration of the cure of polyneuritis is again observed. Only data obtained from successive administration to the same animal of reference standard and assay material (using not less than 8 rats) are to be considered. Data obtained from groups of rats in which the duration of the cure following the administration of assay material is equal to or greater than that produced by the reference standard are suitable for use in calculating the vitamin B_1 potency of the materials under assay.

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(1) 1912. J. State Med. 20, 341.
(2) 1938. J. Am. Med. Assn. 111, 927.
(3) 1938. J. Am. Med. Assn. 110, 727.
(4) 1939. J. Am. Pharm. Assn. 28, 267.
(5) 1939. The Canned Food Reference Manual, American Can Co., New York.

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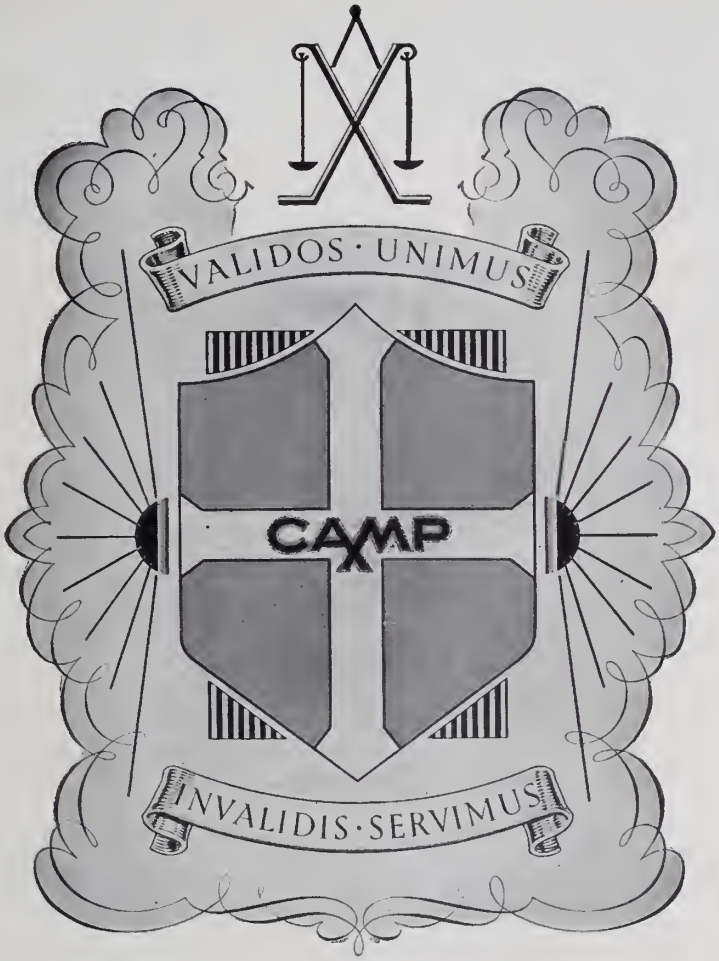

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Sulfanilamide, Neoprontosil and Sulfapyridine; Their Clinical Application*

By ALEX E. BROWN, M. D.
Rochester, Minn.

IT IS difficult to realize that in the last four years an era in chemotherapy has developed which bids fair to furnish pages as brilliant as any which have graced medical history. It hardly seems possible that it is only four years since Domagk's original report on the use of prontosil in the treatment of experimental hemolytic streptococcic infections in mice; and that only three years have passed since the sulfamido compounds were first mentioned in American medical literature.

Unfortunately, space will not allow a recitation of this fascinating history. Neither will it permit a review of the pharmacologic actions of these sulfamido compounds except as they may be mentioned in a general clinical discussion.

Clinical Usefulness of Sulfamido Compounds

In this country at present, there are, to be brief, only three sulfamido drugs, out of a group of more than 200, in which physicians have a practical clinical interest. These compounds in the order in which they have appeared in the field of medicine are neoprontosil, sulfanilamide and sulfapyridine (fig. 1). The original substance, prontosil, is not commercially available in the United States, and may be eliminated from this discussion. It is well to bear in mind the differences and relationships in chemical structure among these aforementioned three drugs. A benzene ring with an amino-sulfone group forms the basis of each; in addition in neoprontosil there is an azo-naphthalene ring and in sulfapyridine a pyridine ring.

The mode of operation of these substances is not definitely known, but seems based on an inhibitory action which varies with different bacteria. This action tends to reduce multiplication of organisms and also to diminish their invasive power. It seems likely that in order to carry the process of bacterial destruction to completion, it is usually necessary also to send into action the various defensive mechanisms of the body.

Conditions Influenced by Sulfamido Compounds

Experience has shown that the most effective action of these sulfamido drugs is obtained against those infections produced by beta hemolytic streptococci, meningococci, gonococci, pneumococci, Clostridium welchii and most of the pathogenic organisms found in the urinary tract.

Observations described in this paper have been made by Dr. Herrell and me in our work with these drugs at the Mayo Clinic.

Sulfanilamide has produced particularly striking results against infections caused by the beta hemolytic streptococcus. This is true of lesions in the region of the eye, ear, nose and throat and also of localized lesions such as those of cellulitis and lymphangitis. It also applies to the treatment by sulfanilamide of such diseases as pneumonia, pelvic cellulitis and erysipelas. In the presence of severe fulminant infections such as septicemia, which previously has had a mortality of at least 70 per cent, and in the presence of meningitis, which previously has had a mortality of almost 100 per cent, results of sul-

* From the Division of Medicine, The Mayo Clinic. Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

fanilamide therapy have been extremely encouraging.

In meningococcic infections, particularly in meningitis, sulfanilamide has given similar striking results.

In infections caused by gonococci, particularly urethritis, the general effect of sulfanilamide has been excellent, and the same is true of various infections of the urinary tract, with the exception of those infections produced by the Streptococcus faecalis.

In pneumococcic infections, especially the pneumococcic pneumonias, the effect of sulfanilamide has not been so favorable as in the foregoing conditions, and, in treating such conditions, sulfapyridine would seem to be the preferable drug to use.

In the treatment of another group of diseases the results obtained with these sulfamido drugs have thus far not been so outstanding, although experience indicates that they have some value. In this group of diseases, undulant fever has responded to properly administered treatment with sulfanilamide. A number of patients having chronic ulcerative colitis, who have been treated by Herrell, Bargen and me, have seemed to benefit by the use of neoprontosil (oral). Infections (including septicemia but with the exception of subacute bacterial endocarditis) referable to the Streptococcus viridans have in many instances responded to concentrations of sulfanilamide in the blood of 10 mg. per cent or more, and sulfapyridine may also prove of benefit in this group. In the treatment of subacute bacterial endocarditis, sulfanilamide or sulfapyridine have controlled the fever and produced negative results in blood cultures for a time, but as a rule the underlying pathologic process has continued unaltered. Dr. Herrell and I, in conjunction with Dr. Benedict and his associates, have treated a small group of patients having trachoma with moderate doses of sulfanilamide and have noted definite improvement. Staphylococcic infections seemingly have been unaffected by sulfanilamide therapy, but we have recently obtained excellent results in several cases of septicemia in which large doses of sulfapyridine were given.

There is a third group of conditions in which the results obtained with sulfamido compounds thus far are open to some debate in regard to the value of such compounds. Among these conditions are those infections produced by anaerobic streptococci and such diseases as tularemia, actinomycosis and rheumatic fever. In the group of virus diseases the sulfamido compounds have been ineffective thus far with the exception of trachoma.

Choosing the Correct Drug

In treating these various infections, considerable care should be exercised in choosing the most suitable drug. Certainly, in infections caused by the hemolytic streptococcus, sulfanilamide, orally administered, seems to be the drug of choice. In the event that this preparation cannot be used orally, it may be given subcutaneously in an 0.8 per cent solution in physiologic saline solution, or neoprontosil in solution may be used. At the clinic, neoprontosil (oral) has yielded favorable results in our hands in certain instances wherein sulfanilamide was not well tolerated. Because of its general lack of toxicity, it has also been used frequently by us in the treatment of chronic ulcerative colitis and in circumstances wherein it has not been possible to keep the patient under close supervision during treatment.

In gonococcic infections the controversy is unsettled regarding the respective merits of sulfanilamide and sulfapyridine, but it must be recalled that the latter is a more toxic preparation than sulfanilamide and that its hazards increase in proportion to prolonged use. The same reasoning applies to infections of the urinary tract. In this latter group of infections neoprontosil (oral) in our experience has not given as satisfactory results as sulfanilamide.

In infections caused by pneumococci or staphylococci, sulfapyridine, as previously stated, in general appears to be the drug of choice.

When dealing with infections caused by meningococci, such as meningitis, it is necessary to realize that the absorption and acetylation of sulfapyridine is markedly variable, and that it is possible to give large

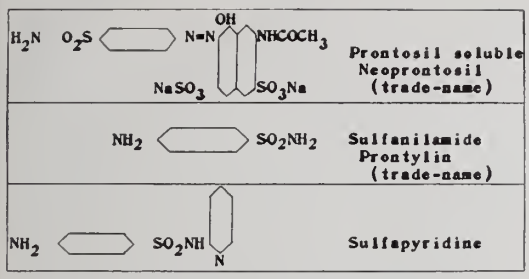

Fig. 1. Sulfamido compounds commonly used in the United States.

doses of this drug without obtaining suitable concentrations in the blood. On the other hand, when using sulfanilamide, it is usually possible to obtain concentrations of the drug in the blood which are fairly well related to the amounts of the drug ingested.

In considering the dosage of these drugs, it must be borne in mind that no set of rules will apply to all cases, and that in general it is desired to obtain a satisfactory concentration of the drug in the blood as soon as possible, because the effect of these drugs is definitely greater in inverse proportion to the duration of the disease and the extent of the foci of infection.

Rationale of Dosage for Sulfanilamide

In using sulfanilamide, it seems reasonable to group the patients to be treated into three classes: First, those who have acute, severe disease, in whose blood high concentrations (10 to 15 mg. per cent) of the drug are desired immediately; second, those patients who have disease of moderate severity, in whose blood moderate concentrations (5 to 9 mg. per cent) of the drug will suffice; third, those patients who have infections of the urinary tract, in whose blood low concentrations (3 to 4 mg. per cent) of the drug will produce satisfactory results.

In the first group, desired concentrations of the drug in a patient's blood usually may be obtained among adults weighing 100 to 150 pounds (45 to 68 kg.) by giving an initial dose of 3.6 to 4.6 gm. of sulfanilamide and then following this dose in four to six hours by 1 to 1.3 gm. given at four-hour intervals. For children weighing 50 to 100 pounds (23 to 45 kg.) a similar procedure may be carried out by administering an initial dose of 3 to 3.6 gm. and then 0.6 to 1.0 gm. of the drug at four-hour intervals. For children weighing 25 to 50 pounds (11 to 45 kg.) an initial dose of 1.6 to 3 gm. may be given, followed at four-hour intervals by 0.3 to 0.6 gm. of the drug.

In the second group of patients who have milder infections, a similar procedure should be followed, but smaller doses will establish the lower concentrations desired in the blood. The necessity for establishing a satisfactory concentration in the blood is not so urgent and, therefore, the initial doses need not be so high. For adults of 100 to 150 pounds the daily maintenance dose is 4 to 6 gm.; for children of 50 to 100 pounds it is 3 to 5 gm. and for children of 25 to 50 pounds, it is 1.6 to 3 gm. In infections of the urinary tract giving 2.6 to 3.3 gm. of sulfanilamide daily to adults will frequently suffice to produce satisfactory results.

In the event that sulfanilamide must be administered subcutaneously in 0.8 per cent in physiologic saline solution, the dose is calculated in the same manner and the daily dose is divided into three parts and given at eight-hour intervals.

The aforementioned doses should be maintained until clinical improvement occurs or toxic manifestations arise. In the event that satisfactory improvement does not occur and satisfactory concentrations of the drug in the blood are not obtained, the amount of the drug administered may be increased. When improvement occurs the daily dose of sulfanilamide may be gradually decreased, but it must be borne in mind that in many infections and particularly in those involving the ear, meninges and bone, there is a tendency for the disease to recur when clinical cure may seem complete. For this reason, it is well in many instances to maintain a daily dose of 3 to 4 gm. of the drug for six to ten days in adults after clinical improvement may seem to be complete. It also seems advisable in the presence of chronic diseases such as gonorrhea and undulant fever, which have a tendency to recur, to give several courses of the drug for twelve to fourteen days at intervals of eight to fourteen days.

Neoprontosil Therapy

When neoprontosil (oral) is used it is well to administer 1 gm. per 20 pounds (9 kg.) of body weight with a maximal daily dose of 6 to 7 gm. Neoprontosil, although it is apparently of low toxicity, has a tendency among certain individuals to produce symptoms of intestinal irritation when large oral doses are employed. When neoprontosil in a solution of 2.5 per cent is used subcutaneously, it usually is best to administer an initial daily dose of 125 cc. and to follow this dose with maintenance amounts of 100 cc. daily divided into several doses. There is no good reason for administering sulfanilamide or neoprontosil intravenously and it is probably best not to use neoprontosil intraspinally. Sulfanilamide, however, may be of some value when it is used early intraspinally in order rapidly to build up a suitable concentration of the drug in the spinal fluid of patients suffering from meningitis.

Sulfapyridine Therapy

Sulfapyridine is administered orally and its absorption and that of sulfanilamide may be aided by powdering the drug in 4 to 6 fluid ounces (118 to 177 cc.) of water or milk. Feedings by tube may be used if necessary.

In using sulfapyridine for pneumonia and severe infections it is well to give an initial dose of 4 gm. to adults and to follow this by a maintenance dose of 1 gm. at four-hour intervals. In therapy directed at the pneumonias, as Marshall and Long have pointed out, it is best to continue this dose until the patient's temperature has remained normal for forty-eight hours; 1 gm. is then administered every six hours until resolution has taken place and then 0.5 gm. may be administered four times daily until recovery has occurred. In severe infections, such as staphylococcic septicemia, we of the clinic have given doses as large as 8.3 gm. daily under close supervision for a period of two weeks. In the treatment of pneumonias not complicated by bacteremia, a concentration of the drug in the blood of at least 4 mg. per cent seems desirable. When bacteremia, staphylococcic septicemia or infection caused by the Welch bacillus is present, it is well to have a concentration in the blood of the patient of at least 10 to 20 mg. per cent. Marshall and Long have shown that when such high concentrations cannot be obtained by oral administration, they may frequently be caused to occur after administering the sodium salt of sulfapyridine intravenously. Usually, 0.6 gm. per kilogram of body weight in a solution of 5 per cent of the sodium salt in distilled water is injected. At the clinic, we have also used a solution of 5 per cent sulfapyridine in 50 per cent glucose intravenously for a few patients, and thus far we have encountered no deleterious effects. These latter two preparations are not yet commercially available. Unfortunately, the relative insolubility of sulfapyridine makes this drug inapplicable for subcutaneous use.

It is well when using sulfanilamide or sulfapyridine to administer 40 to 60 gm. of sodium bicarbonate daily. Ingested with the former, it serves to prevent a decrease in the carbon dioxide combining power of the blood plasma, and ingested with sulfapyridine, it may prevent the formation of renal concentrations. It is well to bear this in mind when using these preparations parenterally, for it is usually necessary in these circumstances to inject intravenously some sodium bicarbonate in a 2.5 per cent or a 5 per cent solution. It is also well to restrict the total fluid intake to 3,000 cc. daily when administering these drugs.

Toxic Manifestations of Sulfamido Compounds

Much has been written regarding the toxic manifestations of these preparations but it is true of sulfanilamide and neoprontosil, that a thorough knowledge of the action of these drugs and close observation of the patient, will largely prevent the occurrence of serious complications.

With the use of sulfanilamide, headache, nausea, vomiting, tinnitus and malaise are among the milder frequently transient effects encountered. Fever may occur between the fifth and tenth days of treatment, but may also occur as early as the first day or after two or three weeks of treatment. It may be of low grade, or may be severe and reach a peak of 106 F. (41.1 C.). It may be associated with repeated chills and it may

closely resemble the fever of sepsis. Usually, the occurrence of fever following a patient's definite clinical improvement will serve to throw suspicion on sulfanilamide as the causative factor. Various types of cutaneous manifestations may be associated or unassociated with fever, and the occurrence of either of these phenomena is usually an indication for discontinuance of the drug.

Cyanosis may occur and usually does occur when large amounts of sulfanilamide are given, particularly in the presence of fever and sepsis. In our experience at the clinic, methemoglobinemia frequently has been present when cyanosis has been noted, and sulfhemoglobinemia has occurred much more rarely than methemoglobinemia. It seems likely that an important factor in the production of cyanosis is a dye-product of the oxidation of sulfanilamide which stains erythrocytes. Undoubtedly, all three of these factors may act simultaneously or successively in producing cyanosis. Experience has shown that of all toxic signs, cyanosis seems of least importance as an indicator of danger unless it is of severe degree and is progressive. We have rarely thought it necessary to combat cyanosis save when this condition has occurred to a severe degree during coincidental respiratory embarrassment resulting from other factors. In this circumstance, for adults, we have used methylene blue (0.1 gm.) every six hours with apparent good result. It should be noted that it is possible for methylene blue to produce toxic effects which may disturb the patient.

Among the severe toxic effects of sulfanilamide is acute anemia, which usually tends to occur during the first week of treatment and which necessitates stopping the drug. Transfusions of blood are of benefit in this condition and also in a milder type of anemia which may be progressive and occur later. Progressive leukopenia is another severe toxic effect of sulfanilamide which usually tends to occur after the first week of treatment and is frequently associated with agranulocytosis. Administration of yellow bone marrow (Stearns) as advocated by Giffin and Watkins seems effective in the treatment of this condition. The usual procedure is to give 50 to 100 capsules (0.22 gm. each) daily until monocytosis occurs and is followed by an increase in leukocytes, when the dose may be decreased. It is well to remember in considering the toxic effects of sulfanilamide that persisting symptoms of mild toxicity, such as headaches or malaise, may presage more serious trouble. When these mild symptoms persist or tend to increase, it is well to exercise unusual caution if the drug is continued, for fatalities have occurred when these warnings have been ignored. When sulfanilamide is used as an optional method of treatment there seems little excuse for the occurrence of serious complications. The occurrence of jaundice during treatment with sulfanilamide is another serious complication which necessitates stopping the drug; an exception might occur when jaundice appears during the course of septicemia as an apparent result of infection. In all these complications cited, recovery will be aided by forcing fluids because the drug is practically entirely eliminated in the urine. Neoprontosil, in contrast to sulfanilamide, seems to be of relatively mild toxicity, whereas sulfapyridine, on the other hand, possesses more toxicity than sulfanilamide. Hematuria and renal calculi have been reported as resulting from the use of sulfapyridine and acute anemia, leukopenia and agranulocytosis have also occurred with alarming frequency following its use. These complications have seemed to occur particularly when the drug has been administered for periods of more than seven days or when the total administered amount has been large. They have been noted, however, to appear after only two days of moderate treatment.

Contraindications

In considering the contraindications to treatment with these drugs, it is necessary to be particularly cautious of the patient who has previously had a marked reaction to one of the drugs for this reaction may recur if the drug is used again. There seems to be no other definite contraindication to the use of these drugs except that in the presence of renal insufficiency it is necessary to exercise caution to prevent accumulation of unusual amounts of the drug in the blood. Experi-

ence has shown that the administration of other drugs simultaneously with these sulfamido compounds does not increase the hazards of therapy. Practically all other drugs, such as digitalis, iodine, aspirin, and the like, may be administered coincidentally, although it is probably best not to use saline laxatives because they may produce sulfhemoglobinemia.

Conclusion

It has been shown that some definite indications exist for the successful employment of these individual sulfamido compounds and that definite measures may be used to prevent and correct the complications that may follow their use.

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Injuries of the Urinary Tract*

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THIS presentation is concerned with a review of urinary tract injuries at the Milwaukee County General Hospital (Dispensary-Emergency Unit) and the Johnston Emergency Hospital, Milwaukee, and of similar injuries observed in private practice, during the years 1934–1939. The emergency aspects and treatment of these injuries are chiefly considered.

In all, seventy-four patients were studied, sixty males and fourteen females. Their ages varied from 16 months to 71 years, the average age being 35 years. Automobile accidents accounted for the vast majority of the injuries, although other causes were also encountered, as shown in Table 1. The types of injuries are given in Table 2.

Symptoms, Complications, Classification

In all urinary tract injuries, hematuria is a cardinal symptom. In this series the symptom varied in degree from microscopic hematuria to hemorrhage sufficiently severe to cause shock. In twenty-five instances this finding was determined by catheterization; in forty it was first noted when the patient voided a bloody urine. In urethral injuries below the triangular ligament, free bleeding from the meatus was seen.

Only one patient with a ruptured urethra was successfully catheterized. Another patient with an almost complete rupture of his urethra was catheterized on entrance, but three days later catheterization was unsuccessful due to sloughing of the injured portion of the urethra.

A patient who suffered a straddle injury of the perineum had free bleeding from his urethra immediately following injury. He urinated freely and without discomfort for four days. On the fifth day, however, he developed soreness and swelling in the perineum and his temperature was 101 F. Examination revealed a tender swelling in the midperineal area immediately posterior to the scrotum, which had the typical appearance of urinary extravasation. This was incised and several ounces of pus evacuated.

Pain was a conspicuous symptom in this series of patients. It was focused over the area of injury and varied greatly in degree. It was most intense in the more severe injuries.

In 60 per cent of the patients there were other immediate and associated complications and injuries. Immediate complications included shock (the most common complication), fractures (pelvis, skull, ribs, long bones, spine), hemorrhage, urinary extravasation, ruptured viscus (lung, liver, bowel), multiple lacerations, abrasions and contusions.

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TABLE 1.—*Causes of Urinary Tract Injuries in 74 Patients*

Type of Accident	Number	Percentage
Automobile	52	70.3
Falling	12	16.2
Football	4	5.4
Baseball	2	2.7
Gun	2	2.7
Fighting	1	1.35
Industrial	1	1.35
Total	74	100.0

Among the various late complications which contributed largely to the mortality were pneumonia, pyelonephritis, osteomyelitis, phlebitis, cellulitis, perinephric abscess and peritonitis. We did not follow any of the patients sufficiently long to determine whether the kidney injuries terminated in atrophy, hydronephrosis or stone formation.

In a general way urinary tract injuries may be divided into injuries of the kidney, ureter, bladder and urethra. However no classification will cover all cases, for on occasion there may be a multiplicity and overlapping of various types of injuries. Following is the classification we have used:

1. Injuries of the kidney
   (a) Contusions
   (b) Intracapsular rupture
   (c) Extracapsular rupture
   (d) Injury to the pedicle
2. Injuries of the ureter and pelvis
3. Injuries of the bladder and prostatic urethra
   (a) Extraperitoneal
   (b) Intraperitoneal
4. Injuries of the urethra below the triangular ligament

Kidney Injuries

Injuries of the kidney were by far the most common in this series (see Table 2). For purposes of description they are divided into the four types named above, namely, contusions, intracapsular rupture, extracapsular rupture and injury to the pedicle.

Contusions to the kidney.—A diagnosis of contusion to the kidney was limited to patients who, following kidney injury, had hematuria but in whom pyelograms did not demonstrate a rupture of the cortex or pelvis of the kidney. This was the type of kidney injury most frequently encountered, as Table 2 shows.

In the forty patients with contusion to the kidney, there was no evidence of extra renal hematoma. There was usually tenderness over the affected side, though it was seldom intense. Muscle spasm was usually absent. Several of the patients showed evidence of shock but it was not intense and was always of short duration unless complicated by some other associated injury. The blood count and hemoglobin remained well within normal limits. The urine usually became grossly clear in twenty-four to forty-eight hours, though on microscopic examination blood was found in the urine for a week or longer.

TABLE 2.—*Types of Urinary Tract Injuries in 74 Patients*

Diagnosis	Number	Percentage
1. Kidney injury		
(a) Contusion	40	54.0
(b) Rupture	10	13.5
2. Ruptured ureter	1	1.3
3. Ruptured bladder	14	19.0
4. Ruptured urethra	9	12.2
Total	74	100.0

There are patients with contusions to the kidney who have no localizing symptoms, and microscopic hematuria is the only evidence of the injury.

Intracapsular ruptures of the kidney.—Three patients suffered intracapsular ruptures of the kidney parenchyma which were demonstrated by retrograde pyelography. In two of them, the laceration extended from a calix for a short distance into the parenchyma. In one, the laceration extended to the capsule and pyelographic solution could be demonstrated underneath the capsule in its middle third. In this group of patients, shock was more marked and prolonged. Hematuria was more intense and persisted over a longer period of time, but there was no evidence of severe anemia. There was marked tenderness over the affected kidney. In the event large clots are passed, ureteral colic may occur in injuries of this type.

In the patients in this group there was no evidence of extra renal hematoma and in none was the temperature ever over 101 F. All made an uneventful recovery on conservative treatment. It is interesting to note that 57 per cent of the patients with definitely ruptured kidneys also had fractured ribs.

Extracapsular ruptures of the kidney and injury to the kidney pedicle.—In the patients with extracapsular rupture of the kidney

there were associated tenderness, rigidity and usually the gradual formation of a palpable mass. Bulging was frequently obvious in the loin. In one patient evidence of a perinephric abscess developed on the tenth day following injury. Drainage of the abscess is all that is necessary in such patients unless the kidney is badly macerated and without form.

In one patient whose kidney was torn in half and separated from its pedicle, there were signs of serious hemorrhage with a progressive fall in blood pressure, hemoglobin and red blood count. In such patients, shock is usually more severe and prolonged.

Ureter and Bladder Injuries

One patient in this series had a ureteral injury (fig. 3). She shot herself with a .32 caliber bullet which perforated the stomach and produced a perfect punched-out hole through both walls of the upper portion of the ureter. Intravenous pyelograms gave the impression of an extracapsular rupture of the lower pole of the kidney. The patient subsequently died of cellulitis and pneumonia, the result of urinary extravasation. At autopsy the true nature of the injury was disclosed.

Injury to the bladder was seen fourteen times, associated in each instance with fracture of the pelvis. The inability to urinate or the urination of but a few drops of bloody urine should immediately make one suspicious of this injury. All the patients in this study suffering this injury had suprapubic tenderness. At the Milwaukee County Emergency Hospital the incidence of ruptured bladder in cases of fractured pelvis is 1 per cent. While this percentage is small, the seriousness of the complication makes it imperative to determine definitely whether the bladder is ruptured.

Two of the fourteen patients with rupture of the bladder voided considerable quantities of urine. One was catheterized and a bloody urine obtained; 300 cc. of boric acid solution were instilled into the bladder and entirely recovered. The patient subsequently voided a clear urine. He had pain in his lower abdomen radiating toward the right kidney fossa and it was believed he had a kidney injury. He ultimately died of pelvic cellulitis due to urinary extravasation along the course of the ureter. In this instance an intravenous pyelogram revealed a partially filled normal bladder. A cystogram made with the bladder well distended with air or an opaque media would have revealed the rupture. In the second and identical case, the patient was given surgical treatment immediately and a perforation glued over by a clot was found on the anterior bladder wall. This patient made a complete recovery. A cystogram revealed this injury. The ability to urinate, while an important finding, may be misleading. It is significant that these two patients urinated and that, in one of them, the cystogram obtained by means of intravenous pyelography did not reveal the ruptured bladder. (Figs. 4 and 5.)

In bladder injuries the signs of urinary extravasation, so vivid in urinary extravasation below the triangular ligament, are lacking. Pain, rigidity and tenderness are present in the lower abdomen along with evidence of sepsis, if the condition is of long standing. With extravasation into the peritoneal cavity, either a septic or chemical peritonitis occurs with the usual picture of peritonitis. Rectal palpation may give evidence of bulging in the cul-de-sac of Douglas in intraperitoneal ruptures of the bladder.

Injuries to Urethra

Pure blood oozing from the urethra is indicative of urethral injury below the triangular ligament. The bulbous urethra, being thin and comparatively unprotected, is commonly injured in straddle injuries. Falling astride a fence, ladder, board or manhole cover is the usual modus operandi. All urethral injuries in this study were of this nature. Forceful instrumentation is also a fairly common cause of urethral injury. The inability to catheterize all but one of the patients in this series was an important diagnostic sign. However, if a catheter is passed to the bladder, releasing a clear urine, the injury is localized to the urethra. A urethrogram is usually of diagnostic value and indicates the degree of extravasation.

In urethral injuries below the triangular ligament, there is always some degree of perineal swelling and ecchymosis. Urination is usually painful. If the patient has urinated, there is evidence of urinary extravasation confined within Colles' fascia; if not, the bladder is usually distended, and the patient has a desire to urinate. One patient was first seen three days after injury. Extravasation had extended into the perineum, genitalia, lower abdomen, and inner thighs. He died of sepsis. Injuries to the membranous urethra are uncommon. They may occur in extensive injuries to the pelvis or when the symphysis pubis has been forcibly separated, resulting in a tear of the triangular ligament and membranous urethra. In this type of injury, urinary extravasation may occur both above and below the triangular ligament.

Differential Diagnosis

Kidney injuries must be differentiated from bladder injuries. Generally this is possible clinically. Boric acid solution usually returns clear after several bladder washings if the kidney alone is injured. Cystoscopy with retrograde pyelography offers the most reliable way of determining the location and extent of the injury.

Intravenous pyelograms are to a large extent unsatisfactory; in shock, the dye is not eliminated in sufficient quantities to get a clear-cut picture. There are also instances of comparatively minor kidney injury in which little or no dye is eliminated from the kidney because of temporary cessation of kidney function. In the majority of cases our pictures have been good or poor depending on the degree of shock. This is a disadvantage if pyelographic information is immediately needed. Further, in a large proportion of cases, the gas in the colon—incident to trauma—has obscured the film to such an extent that it is of no diagnostic value. Whenever we found it imperative to determine the degree of kidney trauma, retrograde pyelography was employed with satisfactory results.

It was obvious that an improvement in diagnosis occurred over the five-year period covering this study. *This was particularly true when a routine type of examination of seriously injured persons was instituted.* The interval elapsing until diagnosis was established averaged ten hours in thirty-two cases and an hour or less in forty-one cases. One instance of ruptured bladder was not recognized as such for forty-eight hours. This patient subsequently died of cellulitis and pyelonephritis. One patient with a ruptured urethra entered the hospital three days after injury and died of pyelonephritis and pneumonia despite adequate treatment.

Treatment

Treatment of ruptured urethra.—In all patients with a completely ruptured urethra and urinary extravasation a suprapubic cystostomy with retrograde catheterization of the urethra was done. This was accomplished by passing a sound from the external and internal orifices of the urethra. The tips of the sounds touch and by careful manipulation the sound traversing the pendulous urethra usually could be directed into the bladder. A 24 F catheter was then threaded onto the sound, pulled through the urethra and anchored. This served as a splint on which the urethra could reunite and heal. The catheter was removed on about the eighth postoperative day.

Three of the patients with rupture of the urethra had perineal extravasation of urine which was treated by wide incision and drainage. If urethral injuries are treated before urinary extravasation takes place, an immediate plastic repair of the urethra may be done. This tends to lessen the amount of scar tissue and stricture formation.

Two patients with urethral injuries died. One of them died two weeks after surgical operation. He was up and about; then, following instrumentation, thrombophlebitis of the pelvis developed. The other one died a week following surgical treatment; the cause of death was pyelonephritis and pneumonia. The mortality rate in patients with urethral injuries was 22 per cent.

Treatment of rupture of the bladder.—In eight of the patients with rupture of the bladder a suprapubic cystostomy was done. Also, the pelvis was adequately drained. Free and prolonged drainage is necessary in these injuries.

One patient not given surgical treatment died on the day of entrance because of skull fracture. Another patient who was not operated on, seen three days after injury, died of peritonitis five days later. One other died in four days from peritonitis. A cystostomized patient died three months after injury from osteomyelitis of the pelvis. A patient with unrecognized rupture of the bladder died on the fifth day after admission of pneumonia and urinary extravasation. The mortality in this group of patients was 36 per cent.

Treatment of kidney injuries.—The vast majority of kidney injuries were treated conservatively. Only four patients with such injuries were subjected to nephrectomy. In none of these was it possible at the time of operation to suture and save the kidney. Of these four patients, one died from peritonitis due to a bullet wound in the colon, which was closed at the time of nephrectomy.

Conservative treatment consisted of sufficient morphine to keep the patient comfortable, an ice cap to the affected side, careful observation and, if necessary, treatment for shock. No patient was treated surgically until recovery was made from shock. One girl, whose kidney was torn in half and separated from the pedicle, was operated on eighteen hours after injury and made a complete recovery. A woman, three months pregnant, who had associated fractured ribs and a stellate extracapsular rupture of the kidney was operated on eight days after the injury and completely recovered.

Of the patients who received no surgical treatment, one died two days after admission of crushing injuries to the chest and shock. Another with a crushed chest and ruptured kidney died three hours after entrance. One died two days after entrance from the effects of a skull fracture. A fourth died of shock and internal injuries. The mortality in patients with frankly ruptured kidneys was 50 per cent.

In this series, all patients who had contusion or intracapsular rupture of the kidney were treated conservatively; no mortality occurred as the result of kidney injury alone. The patients with intracapsular rupture of the kidney suffered more from shock and required longer periods for convalescence, but the end results were good.

Fig. 1. Extracapsular rupture of the kidney; nephrectomy seven days after accident with recovery.

In extracapsular ruptures of the kidney, various factors enter into the determination of whether a patient should be given surgical treatment. The degree of shock, response to the treatment for shock, and anticipation of the degree of operative shock are points which should be evaluated. In addition, one must consider the seriousness of other injuries, the age and general health of the patient, the condition of the remaining kidney, the signs of progressive hemorrhage and the function and extent of morcellation of the injured kidney as determined by pyelograms. The personal skill of the surgeon is also a factor and may influence the type of operation performed.

In injuries to the vascular pedicle, nephrectomy is indicated if the condition of the patient permits. Likewise when a retrograde or intravenous pyelogram indicates the kidney has been so shattered that the conformity of the pelvis and calices has been

essentially lost, nephrectomy is indicated if the condition of the patient permits. Occasionally such a shattered kidney may be sutured and saved. In extracapsular ruptures which maintain to a good degree the conformity of the pelvis, we were content to wait and treat situations as they arose. It is remarkable how well a rather severely injured kidney will heal.

Comment

The mortality rate for all patients with urinary tract injuries in this series was 12.3 per cent. The mortality in those with frankly ruptured kidneys, ruptured bladder and ruptured urethra was 26.4 per cent.

The average stay in the hospital, excluding patients transferred to other institutions, was sixteen days. The shortest stay in the hospital was one day and the longest four and one-half months. The patients whose hospitalization was prolonged had complicating fractures.

It became obvious as this study progressed that the routine type of examination of seriously injured persons, established at the Milwaukee County Emergency Hospital in 1936, had borne fruit. In this routine examination, the injured individual is required to urinate on admission. If this is impossible, he is catheterized. If a grossly clear urine is obtained, we consider a serious urinary injury almost certainly ruled out. If the urine is bloody and the patient's condition allows it, intravenous pyelography is employed. This not only has helped determine the type of injury in many cases but has prevented instances of urinary injury from going unrecognized until serious urinary extravasation has taken place. When intravenous pyelograms are of no diagnostic value, we have not hesitated to employ cystoscopy and retrograde pyelography. The early recognition and adequate treatment of urinary extravasation is essential to a low mortality rate.

Fig. 2. Intracapsular rupture of the kidney; recovery on conservative treatment. (Photograph loaned to the author by Dr. J. C. Sargent, Milwaukee, with whom he is associated in practice.)

Fig. 3. Bullet wound of left ureter with urinary extravasation.

In kidney injuries we have inclined to conservative treatment, not only because the vast majority of kidney injuries are not serious, but because patients with serious kidney injuries often have serious complicating injuries and are shocked to such an extent that immediate surgery adds an unjustified danger. Except in unusual circumstances, we treat surgically only badly morcellated kidneys, postponing nephrectomy until the patient's condition is improved.

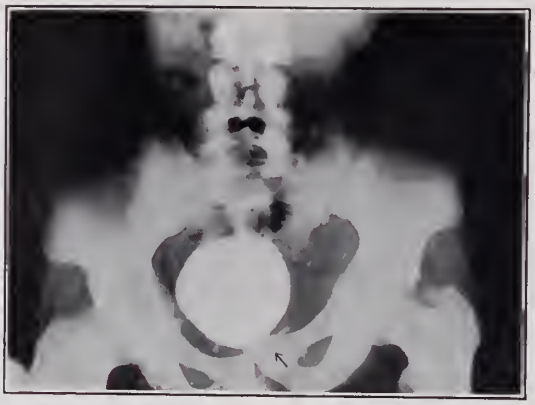

Fig. 4. Extraperitoneal rupture of the bladder.

Fig. 5. Cystogram obtained by intravenous pyelography. Fig. 4 shows cystogram taken in same case with well distended bladder.

Fig. 6. Urethrogram showing extravasation in region of bulbous urethra.

SPRING CLINIC DAYS

Dates for the annual spring clinics sponsored by the Council on Scientific Work of the State Medical Society have been set for April 24, 25 and 26. Clinics this year will be held in Wausau, Watertown and La Crosse. Make arrangements now to attend one of these spring clinic days.

Some Types of Acute Cervical Cellulitis*

By SAMUEL J. PEARLMAN, M. D.
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EARLY in the present century, Mosher[1] called attention to infections deep in the neck and springing, as a rule, from lesions about the tonsillar area. He designated these infections as a form of perijugulitis. It was not however, until 1929 when he again addressed the medical profession that, in an exposition notable for its clarity,[2] he brought home, at least to American laryngologists, the salient features of these infections. It seemed, suddenly, that all was clear now which before had been but poorly understood. Mosher swept aside the conventional anatomical descriptions of the neck. He refused to allow a complex cervical fascia to confuse the picture and in a few phrases made clear what one had to know about pus deep in the neck.

Wassmund[3] has done the same thing for infections starting in the floor of the mouth, and it is these infections which will be discussed here. He has pointed out that such infections are not well understood by a large part of the profession; they start frequently from trivial lesions about the teeth and gums; they vary markedly in severity; and, starting ofttimes in an apparently benign manner, they may progress in a few hours with such rapidity, and spread with such dramatic suddenness to parts apparently far removed from the original lesion that the frequently encountered fatal ending comes as a complete surprise to the attending physician.

A better understanding of infections of the floor of the mouth can be obtained if the term "Ludwig's angina," is disregarded. In the first place, angina refers to suffocative attacks which are only one of a number of important symptoms in these infections. And while no one debates the propriety of naming a disease after the person who first, or in the best manner, brought it to the attention of the profession, in this instance it has served to maintain the confused understanding which persists in many places even now.

Infections of the floor of the mouth may be benign or severe. The benign ones usually reach the floor of the mouth by way of the lymphatic nodes. They start as a lymphadenitis usually from lesions about the lips, teeth and gums; they may progress to forms of periadenitis; the glands may suppurate, but as a rule these infections are limited and, when pus forms and is evacuated, healing is rapid. The more severe types partake of the nature of a phlegmon. They start in the loose areolar tissues of the various spaces of the floor of the mouth, carried there by direct trauma or from infections about the roots of teeth which break directly into the spaces about to be described. They may arise, furthermore, from compound fractures of the mandible; after infiltration with local anesthetics; and from suppurations supervening upon the extraction of teeth. A benign form starting in lymph nodes in one particular area may become a phlegmon after it has spread to another area.

Anatomical Considerations

Infections of the floor of the mouth always start in one of several anatomical spaces; namely, (1) the submental space; (2) the space between the extrinsic muscles of the tongue; (3) the sublingual space; (4) the submaxillary fossa.

Without any attempt to give a detailed anatomical description, the following will probably be sufficient from the clinical point of view to make clear the mode of spread from one space to another in the floor of the mouth; from one side to another; and from the floor of the mouth to other areas more or less remote from the origin of the infection.

The submental space.—The submental space is bounded above by the mylohyoid muscle, laterally by the anterior bellies of the digastric muscles, and beneath by the

* Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

deep cervical fascia. It contains fat, loose areolar tissue, and a few lymph nodes. When severely involved, necrosis of muscle barriers takes place and the submaxillary and sublingual areas are invaded with ease.

The space between the extrinsic muscles of the tongue.—The space between the extrinsic muscles of the tongue is bounded laterally by the geniohyoid and genioglossus muscles and below by the mylohyoid muscle. This space is involved usually by carious processes arising one way or another in the mandible.

The sublingual space.—Phlegmonous infections tend quickly to spread toward the sublingual space on each side. The latter space is bounded below by the mylohyoid muscle, laterally by the mandible, and above by the mucosa of the mouth. Medially, the space opens directly into the space of the extrinsic muscles of the tongue, and posteriorly it opens directly into the submaxillary fossa at the posterior margin of the mylohyoid muscle. A phlegmon in this area quickly invades the submaxillary fossa on the same side as well as the opposite sublingual space.

The contents of this space consist of the sublingual gland, lymph nodes, loose areolar tissue, Wharton's duct and various nerves and blood vessels. The space may be involved by traumata; it may be invaded by infections about the roots of teeth, infections due to salivary calculi or those arising after extractions of molar and premolar teeth.

The submaxillary fossa.—Lastly, the submaxillary fossa is bounded laterally by a subdivision of the deep cervical fascia which is strongly attached to the hyoid bone below and the mandible above. Medially are the hyoglossus and mylohyoid muscles. Above is the oral mucous membrane. Below and anteriorly is the anterior belly of the digastric muscle. Posteriorly are the posterior belly of the digastric muscle and a fold of deep cervical fascia which, running upward, contains the posterior facial vein and becomes part of the parotid fossa fascia. This explains the ease with which this latter area may become involved.

The submaxillary fossa and the parapharyngeal spaces lie in close relationship to each other so that infections can pass easily from the former to the latter. It was Mosher's great service to point out the submaxillary fossa approach to the parapharyngeal space. Pus as well as the surgeon's finger may find its way from the submaxillary fossa beneath the posterior belly of the digastric muscle to the carotid sheath.

The submaxillary fossa is also closely connected anatomically with the sublingual space. They are separated from each other by the mylohyoid muscle but both spaces join at the posterior border of this muscle, where Wharton's duct leaves the submaxillary gland to run through the sublingual space, accompanied by the so-called oral prolongation of the submaxillary gland.

This anatomical consideration reveals the reasons why infections in the floor of the mouth starting in one space may spread to the others and across the midline.

General Considerations

Death, when it supervenes in infections limited to the floor of the mouth, is from suffocation due to the fact that the tongue is pushed markedly upward and backward.

Sepsis, which is said to be responsible for 50 per cent of the deaths, is due to involvement of veins, usually the internal jugular vein in its course through the parapharyngeal space.

Mediastinitis is due to the descent of pus from the parapharyngeal space along the great vessels of the neck into the chest. It also occurs when the retropharyngeal space is involved secondarily to the parapharyngeal space with which it is in direct communication. In this instance, the pus extends alongside the esophagus. These secondary parapharyngeal space involvements, in the experience of some, more often cause death by meningitis than by mediastinitis.

The meninges may be attacked, when the parapharyngeal space is involved, by direct extension of pus through the various foramina in the base of the skull. It also follows in a more characteristic fashion secondary to a cavernous sinus thrombosis which is produced by a thrombosis of the pterygoid plexus of veins lying in the ptery-

gomaxillary space. This latter is invaded because it is in direct communication with the parapharyngeal space.

Somewhat remote, but no less interesting and often inexplicable to the uninitiated, are parotid space infections secondary to phlegmons of the floor of the mouth. The parotid space may be involved by way of the parapharyngeal space due to the fact that the parotid fascia posteriorly is incomplete and the two spaces lie in contact with each other. It may also be involved by way of the submaxillary space for the fascia which forms the posterior border of this latter area and which contains within it the posterior facial vein runs up to fuse with the fascia forming the boundaries of the parotid space. In parts thick, this fascia in other locations is thin and permits the passage of infection upward from the submaxillary space.

Symptomatology

A few words as to symptomatology in these infections may not be out of place at this time. It will help to make things clearer if we discuss in a semi-theoretical manner the symptoms as they appear in the individual involvement of the various spaces.

There is no need to discuss the findings in *submental space* inflammations as they are obvious.

Isolated suppurations in the *submaxillary fossa* are characterized chiefly by a trismus of more or less degree. This is due to infiltration and spasm of the muscles of mastication, chiefly the internal pterygoid muscle. There is pain on swallowing which increases considerably with further involvement of the parapharyngeal and sublingual spaces. The tongue is usually not swollen and there are, of course, the external signs of submaxillary space involvement.

In widespread involvement of the *sublingual fossa* there is little or no trismus, no muscles of mastication being involved. In the absence of trismus, it is possible to examine the mouth, something which is very difficult in submaxillary space involvement. The mucosa of the mouth is elevated on one or both sides and is red. The tongue is elevated and swollen and there may be some stridor. There is much pain on swallowing and the speech is thick and muffled.

Symptoms of abscesses in the region of the *extrinsic muscles of the tongue* resemble closely those in the sublingual fossa. The tongue is more markedly swollen and infiltrated and tender to the touch posteriorly in the region of the foramen cecum. As a rule, trismus is absent.

There are types of acute cervical cellulitis which spring from inflammations about the tonsils rather than from lesions about the lips, teeth, and gums, as in the aforementioned ailments.[4] They are not apt to invade the floor of the mouth. They take place in the parapharyngeal space. Springing from the tonsil as they do, however, a few words about the anatomy of this region are essential. Mosher[2] has done this admirably.

In the inner boundary of the parapharyngeal fossa is the superior constrictor muscle with the tonsil attached to it. The outer boundary below is the internal pterygoid muscle lining the inner surface of the ascending ramus of the jaw and mating the masseter on the outside. The outer boundary above is the parotid gland, the gland at this point not being covered by fasciae. Posteriorly, the prevertebral muscles and the prevertebral fascia bound the fossa. The fossa is divided into two unequal compartments by the styloid process and the muscles rising from it. These are in front of the great vessels and protect them. The anterior, muscular or prestyloid compartment contains no large vessels or nerve trunks. The posterior, vascular or retrostyloid compartment contains the carotid artery, jugular vein, the glossopharyngeal, vagus and hypoglossal, spinal accessory and cervical sympathetic nerves.

The tonsil, lying as it does on the superior constrictor muscle, one of the boundaries of the space may, when infected, be the cause of invasion of the parapharyngeal space. This invasion may be brought about in more than one way. Rapidly fatal forms may occur directly by invasion of abscesses or secondarily following lymphadenitic and thrombophlebitic processes. Pus, when present in the vascular compartment, has a pathway

direct from the skull above to the mediastinum below.

Following tonsillitis, perhaps mild, or more often after a "quinsy sore throat," severe symptoms appear. The trismus of the quinsy which should have disappeared upon adequate drainage, persists, being due mainly to inflammatory involvement of the internal pterygoid muscle, one of the boundaries of the parapharyngeal space.

Fever is nearly always present and is of the type usually seen in sepsis. At times it may be high and continuous. Chills are frequent. There may be a mild jaundice. Locally, especially when pus is present, a brawny induration develops in the neck especially about the angle of the jaw. This is absent in the rapidly progressing types due to primary blood invasion and to retrograde thrombophlebitis from the tonsillar vein to the internal jugular vein; the same is true of bulging of the lateral pharyngeal wall on the affected side seen only when pus is present. There may be, in addition, some tenderness over the course of the jugular vein.

Treatment

Local treatment.—The surgery indicated in phlegmons of the floor of the mouth follows logically from a consideration of the spaces involved. The space between the extrinsic muscles of the tongue is reached by a midline incision from the mandible to the hyoid bone. The incision goes through skin, subcutaneous tissue and deep fascia, to and through the mylohyoid muscle. The exploring finger or forceps may be carried to the base of the tongue with counter palpation, if possible, in the mouth. The submaxillary fossa and sublingual spaces may be reached by incisions parallel to the mandible when they become approachable by the finger or the forceps. Collar approaches, and, best of all, Mosher's submaxillary approach will permit investigation of every area involved.

Tracheotomy is often necessary and when indicated should not be too long delayed.

As for parapharyngeal space abscesses and phlegmons, Mosher's advocacy of the submaxillary fossa approach is logical and highly efficient. He recommends a generous T shaped incision. The skin flaps are retracted and the lower border of the submaxillary gland defined. The gland lies between the two bellies of the digastric muscle as in a sling, and is lifted upward.

The facial vein is tied and cut. The finger or blunt forceps, carried up beneath the posterior belly of the digastric muscle, finds the carotid sheath and, if it is present, pus. The styloid process is easily palpable and accumulations about the base of the skull may be evacuated. This exposure allows for examination of the base of the tongue and the floor of the mouth as well as the entire neck from the base of the skull downward. The internal jugular vein is easily inspected, and ligation and resection carried out if necessary.

Other external approaches have been advocated by Marschik, Kramm and Batson.

In some benign forms of these infections, in which there is obvious bulging of the pharynx, a forceps carried through the superior constrictor muscle may at times adequately drain the parapharyngeal space.

General anesthetics should be avoided because of the danger of asphyxia. Infiltration anesthesia, though recommended by some, is risky, because of the possibility of carrying additional infection into the deep tissues.

Hemorrhages from erosion of large vessels, usually the internal and common carotid arteries, are best handled by immediate ligation of the carotid vessel.

General treatment.—General measures such as repeated small blood transfusions and the use of sulfanilamide and related drugs should be used as indicated in individual cases.

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Fibrosarcoma of the Optic Nerve

Report of Case*

By J. W. TANNER, M. D., and A. J. HERTZOG, M. D.
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PRIMARY tumors of the optic nerve are rare. According to Mehney,[1] only four have been observed at the Massachusetts Eye and Ear Infirmary in thirty-six years, and only one at the Wills Hospital in Philadelphia in twelve years. The tumor may involve either the intraorbital or the intracranial portion of the optic nerve. The former is more common. Usually the earliest symptom is a gradual unilateral loss of vision followed by a painless exophthalmus on the affected side. Examination of the fundus reveals optic atrophy or choking of the disk. Roentgenologic study of the optic foramina and sella turcica is especially valuable as a diagnostic procedure. Visual field determinations are important, especially for those tumors involving the intracranial portion of the optic nerve, as exophthalmus may be absent and the only finding a loss of vision in one or both eyes.

Case Report

A 3 year old male child was first seen on February 12, 1937, because his parents had noticed a gradual bulging and turning out of his right eye. This had been present for the past twelve to fifteen months. He had not complained of any pain and his general health had been good.

Examination showed a moderate proptosis of the right eye, which was turned outward about 25 degrees. The pupils were of equal diameter and reacted to light and accommodation. The right optic disk was pale and suggested an optic atrophy. The left disk appeared normal. The vision in his right eye was reduced to light perception and the vision of his left eye was normal. An x-ray examination of the orbit and sinuses was advised. However, this was done elsewhere, and he was given a course of x-ray therapy by another physician.

He was not seen again by the authors until June 1, 1938. At this time, the proptosis had increased (fig. 1) and the vision in his right eye was completely destroyed. An x-ray examination showed a marked erosion of the optic canal. The bony margin surrounding the optic nerve was eroded in its inferior portion until it was continuous with the sphenoid fissure. On June 2, 1939, the right eyeball was removed, together with the intraorbital portion of the optic nerve. A large fusiform tumor measuring 4 x 2.8 x 2.4 cm. was found arising from the distal portion of the optic nerve (fig. 2). The eyeball itself was not involved. The growth extended to the optic foramen where it was excised. The patient made an uneventful recovery from the operation.

Microscopic examination: Sections stained with hematoxylin and eosin and Mallory's azocarmine stain showed the tumor to be composed of a mixture of well differentiated collagenous fibers and elongated, relatively undifferentiated cells (fig. 3). These cells in the undifferentiated areas possessed spindle shaped hyperchromatic nuclei and were surrounded by a conspicuous amount of cytoplasm. An occasional mitotic figure was seen. There was a direct transition between the well differentiated collagenous fibers and the more rapidly growing spindle shaped cells. The diagnosis was fibrosarcoma, grade 1, of the optic nerve.

Discussion

The lack of general agreement concerning the classification of optic nerve tumors has lead to a rather confusing histopathologic classification. The majority of reported cases are called gliomas and the term is used loosely to include several distinct types of tumors including neuroepitheliomas of the retina. It would seem better since the fundamental work of Bailey and Cushing to restrict the term, glioma, to tumors arising from the glial tissue of the nervous system. These comprise the common brain tumors and consist of several varieties such as spongioblastomas and astrocytomas. However, examples of true gliomas arising from the optic nerve have been reported by Mehney,[1] Kiehle,[2] DeLong,[3] Grinker,[4] and others. The abundant formation of collagenous fibrous connective tissue found in the majority of optic nerve tumors suggests that they arise from the connective tissue of the nerve trunk or the sheath of Schwann and are hence properly called neurofibromas.

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* From the departments of ophthalmology and pathology of Luther Hospital, Eau Claire.

Fig. 1. Exophthalmus with outward rotation of right eye is shown.

When the growth becomes malignant, it assumes the structure of a fibrosarcoma, myxosarcoma, or rarely the structure of an undifferentiated sarcoma. Sometimes tumors of the optic nerve are associated with multiple neurofibromas elsewhere in the body as seen in von Recklinghausen's disease.

The prognosis depends largely on the location of the tumor. If the intraorbital portion of the nerve is involved and the tumor can be completely removed, the prognosis for life is good. If the intracranial portion of the optic nerve is affected, the prognosis for life is poor because of the surgical difficulty of completely removing the growth. The possibility of intracranial involvement in this case was considered, but fifteen months after operation there was no evidence of any recurrence. The child now wears an artificial eye and is attending school.

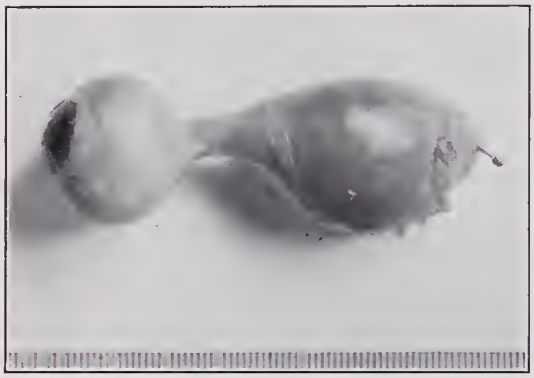

Fig. 2. Gross surgical specimen showing tumor arising from optic nerve.

Summary

Primary tumors of the optic nerve are rare. They may involve either the intraorbital or the intracranial portion of the nerve. The prognosis depends largely on whether the tumor can be completely removed. A case is reported of an optic nerve tumor occurring in a 3 year old child. It proved to be a fibrosarcoma of low grade malignancy.

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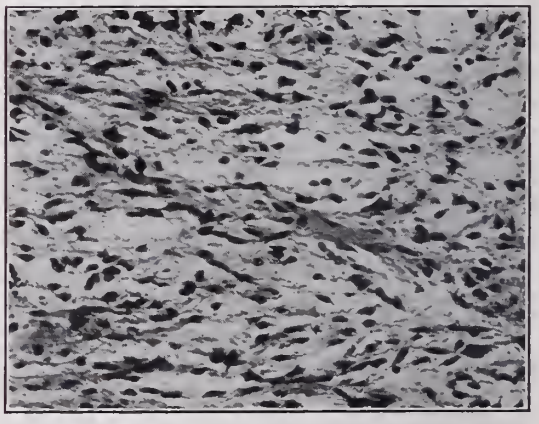

Fig. 3. Photomicrograph showing collagenous fibers and elongated cells.

SPRING CLINIC PROGRAM

Watch the next three issues of THE JOURNAL for information on the Spring Clinics being sponsored by the Council on Scientific Work of the State Medical Society, April 24, 25 and 26 in La Crosse, Watertown and Wausau.

Bleeding Due to Capillary Defect

By FREDERICK W. MADISON, M. D., and THEODORE L. SQUIER, M. D.
Milwaukee

THE earliest recorded observations of the relationship of impairment of the capillary endothelium to pathological bleeding were those of Hayem[1] and of Laseque and Legroux[2] in individuals with scurvy dying during the siege of Paris in 1871. They described extensive fatty degeneration of the cells lining the capillary walls which they felt made possible the extravasation of blood from the vascular bed. These findings were corroborated by Findlay[3] in 1921 who produced scurvy experimentally in the guinea pig and was able to demonstrate not only swelling and degeneration of the capillary endothelial cells but diapedesis of erythrocytes through the intercellular cement substance between those cells. Leede[4] in 1911 observed that in severe cases of scarlet fever there were occasionally multiple petechial hemorrhages in the skin which he felt were due to capillary damage. With Rumpel he found that if the venous return from the arm was obstructed in such cases, multiple petechiae appeared below the site of obstruction. This phenomenon which bears their names was interpreted to indicate a weakening of the capillary wall to such an extent that a relatively slight increase in intracapillary pressure was sufficient to force blood cells through the capillary walls.

Then from the experimental studies of purpura came evidence of impairment of the capillary endothelium in that desease. Nolf[5] in 1911 suggested that defect of the coagulation mechanism in purpura was not sufficient to explain the presence of bleeding in all instances and suggested the possibility of capillary abnormality. Roskam[6] in 1921 observed that variations in bleeding time in purpura were dependent not only upon the degree of thrombopenia but upon the "vascular factor" as well, and finally Bedson[7] in 1922 in his classical "agar serum" experiments showed that spontaneous bleeding would not occur if only a thrombopenia were produced but that if the capillary endothelium was damaged at the same time spontaneous hemorrhage and the typical picture of purpura appeared promptly. In 1932 Jones and Tocantins[8] in a clinical study of purpura said "In our opinion the essential feature in purpuric conditions is not platelet reduction but capillary hyperpermeability." In 1937 Madison and Squier[9] pointed out the clinical importance of capillary erythropermeability in all types of purpura, in "idiopathic" hemorrhages from the mucous membranes, in "easy bruising," in the spontaneous subcutaneous hemorrhages preceded by sudden sharp stinging localized pains, in severe infections, and in terminal illnesses.

Over the past two years we have continued to study these capillary changes in relation to pathological bleeding. We have used two methods of determining the erythropermeability of the capillary walls in practically all instances. The Rumpel–Leede method is the test originally described by Leede and consists of inducing a positive intracapillary pressure in the arm by means of an inflated blood pressure cuff and measuring quantitatively the amount of blood forced out of the capillary walls in a given period of time by counting the number of petechiae appearing in a circle 5 cm. in diameter, 4 cm. below the site of obstruction. The other method employs negative extracapillary pressure in which the minimum negative pressure which will cause the appearance of petechiae in the area exposed is determined.

We have applied these tests more or less routinely in an unselected group of office and hospital patients, and have attempted in the positive reactors to investigate etiologic possibilities as carefully as possible. Not entirely in accord with a similar study by

* Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

Schour,[10] we have found these positive reactors to fall into seven more or less well defined groups as indicated in Table 1.

TABLE 1.—*Conditions Found in Association With Capillary Erythropermeability*

1. Vitamin C deficiency
   - Clinical
   - Subclinical
2. Severe infections
   - Scarlet fever
   - Pneumonia (terminal)
   - Bacteremia
   - Subacute bacterial endocarditis
3. Malignant disease (terminal phase)
4. Malignant hypertension
5. Primary blood disease
   - Leukemia
   - Multiple myeloma
   - Leukothrombopenia
   - Aplastic anemia
   - Purpura
     - Thrombocytopenic and nonthrombocytopenic
     - Easy bruising — "occasional" hemorrhage
6. Allergic reactions
7. Ovarian dysfunction

Discussion

Group 1—There seems to be rather general agreement that vitamin C deficiency of a degree sufficient to cause the clinical condition known as scurvy causes an increased permeability of the capillary walls for red cells as shown by the experimental studies of Findlay[3] in guinea pigs and as is evidenced by the spontaneous bleeding of clinical scurvy. There is no demonstrable coagulation defect in scurvy and bleeding is therefore not severe. Findlay suggested two possible explanations of the mechanism involved, either or both of which may be correct. He found that the actual diapedesis of the red cells occurred through the intercellular substance between the endothelial cells. He also found swelling of the endothelial cells and postulated either that tension on the intercellular substance by the swollen cells or an impairment of the intercellular substance by the deficiency of vitamin C was the responsible mechanism. Wolbach[11] very strongly supports the latter view, feeling that one of the most important functions of vitamin C is its role in the formation and maintenance of all intercellular substances. Whether subclinical vitamin C deficiency is capable of causing recognizable increase of the capillary permeability is a more difficult question and one which is not yet settled. At the present time we have the view of Wright on the one hand who feels that all demonstrable capillary erythropermeability is due to vitamin C deficiency and on the other the observations of Croft and Snorf[12] who found 38 per cent of an unselected group of hospital patients to have subclinical vitamin C deficiency and none of them had bleeding or capillary erythropermeability. It is safe to say however that no one at the present time will deny that deficiency of vitamin C may cause capillary erythropermeability which may or may not result in clinical bleeding.

Group 2.—In the next group of patients showing positive capillary permeability tests we have included all those who have had illnesses due to bacterial invasion and we have found almost without exception that these patients have been extremely ill and in many instances have died. We have previously classified these capillary reactions as "toxic" and still have no better name for them. No knowledge of the histologic changes in the capillary walls in this group is available at the present time. It is perhaps of interest to note that in our experience practically all cases of bacterial endocarditis show capillary changes sooner or later in the course of the disease. In this group again there is no coagulation defect and bleeding is rare. If it does occur it is limited to minor mucous membrane bleeding or petechial spots.

Groups 3 and 4.—It is probable that the increased permeability found not infrequently in the terminal phases of malignant disease belongs in the same group as the severe infections. Malignant hypertension presents a somewhat different problem and it would seem not unlikely that the capillary changes are merely a phase of the general vascular reaction that is a fundamental part of that disease. It is to be noted that in the few cases of this type that we have seen the capillary reaction has been strikingly positive. As is well known, moderately severe hemorrhage in the lung, kidney and subcutaneous tissue is not unusual in this disease.

Group 5.—In the next large group have been included the diseases that are called primary blood diseases or dyscrasias. All of the acute leukemias that we have seen and many of acute exacerbations of the chronic leukemias have shown strongly positive reactions and, as is common experience, have shown clinical bleeding of varying degree. Two cases of multiple myeloma have shown strongly positive erythropermeability with-

out clinical bleeding. The remaining three blood diseases are ones which are characterized by severe clinical bleeding at one time or another and are the clinical states in which the capillary reactions have been most strongly positive. It is interesting that all of these diseases are ones in which we have attempted to show that the cellular changes were manifestations of what we have called hemato-allergic reactions. The significant cellular change in each of them from the standpoint of bleeding is the reduction of platelets which according to present concepts results in a deficiency of thromboplastin and therefore causes a defect in coagulation. The severity of the bleeding in these cases is undoubtedly due to the presence of both a coagulation and a vascular defect. It is from this group of diseases that the first suggestion of an allergic mechanism in the altered capillary state was derived.

Group 6.—Study of group 5 led us to the observation that many allergic patients with or without minor clinical bleeding showed varying degrees of capillary erythropermeability. That observation led us in turn to a search for more positive evidence of the effect of allergic reactions on the capillary walls. The following case report demonstrates such evidence clearly:

Case 1.—V. D., aged 24, secretary, was referred with a diagnosis of thrombocytopenic purpura on July 11, 1938. Following an acute upper respiratory infection six weeks previously she had had an abnormally profuse menstrual flow. A few days later severe nasal hemorrhage had occurred and was followed by subcutaneous ecchymoses and petechial spots. Nosebleed had been common throughout her earlier years. The clinical picture was that of purpura with a moderate thrombopenia and a slight increase in capillary erythropermeability. The next day an ingestion test was done with one pint of milk. Prior to the ingestion the Rumpel–Leede test showed four petechiae in the standard circle. Thirty minutes after the ingestion the same test showed thirty-nine petechiae in the same circle. Twenty-four hours later the capillary test showed six petechiae. This observation was repeated fifteen days later with an exactly similar result.

We have no positive knowledge of the histologic changes present in this type of reaction but it is tempting to visualize a swelling of the endothelial cells such as Findlay has described in experimental vitamin C deficiency and such as is known to be a fundamental phase of all tissue reactions to allergins with a resulting tension on the intercellular substance which then permits the red blood cells to pass through. The prompt reversibility of the capillary changes, seen in case 1, lends some support to this view.

Group 7.—The group which remains is thus far the most puzzling from the standpoint of the mechanism involved. The patients in this group which we have observed have been few in number and have shown no clinical bleeding and only very mildly positive capillary reactions. Clinically they have shown vague symptoms that are generally regarded as being evidence of ovarian dysfunction—ovulation pain, menstrual irregularities, dysmenorrhea and vague premenstrual discomfort in varying degrees. We have observed an increased capillary permeability at ovulation time and in the few days prior to menstruation and in one instance have been able to abolish the altered permeability at least temporarily by the use of estrogenic hormone. These observations are in accord with those of Bickel[13] to some extent but need much further study before their significance can be known. We feel however that there is justification for the thought that endocrine factors may in some way be capable of altering the permeability of the capillary walls for red blood cells. It is entirely probable that a localized increase of capillary permeability is a factor in normal menstruation.

It is thus obvious that our knowledge of the pathogenesis of capillary erythropermeability is too inadequate to offer much in the way of practical value. We do feel however that routine testing of the permeability of the capillary walls is an important part of every diagnostic examination, especially in the presence of a history of abnormal bleeding after trauma, or spontaneous bleeding or "bruising," and may provide information that could not be gained otherwise. In the presence of a positive reaction, severe infection, primary blood dyscrasias and malignancy should be searched for and ruled out carefully. After that has been done, the possibility of vitamin C deficiency should be

considered and not only should determination of plasma cevitamic acid be done but the patient should have a test period of at least one month on a diet high in vitamin C supplemented by 100 mg. or more of cevitamic acid daily. If at the end of that time the permeability of the capillaries has not changed, a careful search should be made for allergic possibilities. If such sensitivities are found, an adequate period of allergic control should follow. If the solution is still not found and if blood loss is of sufficient magnitude to threaten the life of the individual, one should consider removal of the spleen which has been shown at least in some of the purpuras to have a beneficial effect on the permeability of the capillary walls. If actual blood loss is not a serious factor, removal of focal infection (if feasible), rest and general hygienic measures should be carried out. In women the possibility of endocrine factors is always present and in the present state of our knowledge, trial therapy with at least the estrogenic hormones seems to be justified.

Summary

1. In all cases of abnormal bleeding, the erythropermeability of the capillary walls should be determined. Increased permeability of the capillary walls for red blood cells is always a pathological finding and demands etiologic investigation. It may exist in varying degrees and may or may not be associated with clinical bleeding. Spontaneous bleeding cannot occur without it, however great a defect in coagulation mechanism may be present. If it is present together with a coagulation defect, bleeding will almost certainly be severe.

2. We have found capillary erythropermeability associated with vitamin C deficiency, severe infections, terminal phases of malignant disease, malignant hypertension, primary blood disease, allergic states and ovarian disorders.

3. Successful treatment of the capillary abnormality must be based on correct interpretation of the etiologic factors. Proper use of cevitamic acid, allergic control, ovarian hormones and, in occasional instances, perhaps splenectomy, will help to solve many clinical bleeding problems.

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EXAMINATIONS AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting in Atlantic City, N. J., on June 8, 9, 10, and 11, 1940, immediately prior to the annual meeting of the American Medical Association in New York City.

Application for admission to Group A, Part II, examinations must be on file in the secretary's office not later than March 15, 1940.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I and Part II examinations.

For further information and application blanks, address Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

Comments on Treatment

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M. H. Seevers, M. D., University of Wisconsin, Madison

Plasma Transfusion

In a previous issue of this Journal difficulties of a blood bank in a small hospital were pointed out. Recently the writer, while attending the annual meeting of the Medical Society of the State of Pennsylvania, saw the exhibit of Dr. Max Strumia of the Bryn Mawr Hospital on "Plasma Transfusion." Since this exhibit demonstrated a plan which covers the needs of a small hospital, the following explanation of it may be advantageous.

The blood is collected under sterile conditions. For each 500 cc. of blood, 100 cc. of saline and 2 gm. of sodium citrate are added. Centrifugation likewise is carried out aseptically, and the plasma obtained is transferred to sterile glass containers. Enough merthiolate is added to yield a 1:10,000 concentration. The material is kept at 2 to 4 C. Under these conditions it can be preserved for one month.

Plasma for transfusion offers certain advantages over whole blood. It is ready for immediate use. No typing or cross agglutination is required, and the danger of improper matching of bloods is remote. As a word of precaution, if large amounts of plasma are injected, it is advisable to cross agglutinate the patient's cells with the plasma that is to be injected. The plasma can be given in large and repeated doses without the dangers of untoward reactions that sometimes occur if stored whole blood is used.

Plasma will function as well as whole blood in all conditions except those in which an acute deficiency of hemoglobin, the oxygen carrying agent, is encountered. In severe shock, plasma serves as efficiently as blood, unless severe hemorrhage preceded shock. Since plasma is the carrier of specific and nonspecific immune bodies, as much probably can be accomplished by injecting plasma for the combating of infections as by giving blood. In diseases accompanied by low plasma proteins, such as nephritis, chronic infections, extensive burns, ulcerative colitis and hepatitis, the parenteral administration of plasma will specifically aid in correcting such a deficiency.

It is important to recognize that plasma cannot replace whole blood in all conditions. In severe hemorrhage, blood rather than plasma must be used since one of the main aims of the transfusion is to restore the level of hemoglobin. Likewise in certain blood dyscrasias, especially those with a hemorrhagic tendency, blood and not plasma is indicated. In acute poisoning affecting the hemoglobin, such as results from nitrobenzol and other industrial poisons, only whole blood can bring about the desired restoration of the oxygen-carrying capacity of the blood. Transfusion with whole blood also serves as a palliative in various forms of hypoplastic anemias.

Many conditions demand a transfusion with whole blood, and for these the small hospital is well prepared. But for emergencies such as shock when delay, which is almost always associated with the ordinary transfusion, may lead to serious consequences, a "plasma bank" may be of inestimable value. A. J. Q.

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« « « EDITORIALS » » »

99th ANNIVERSARY MEETING, STATE MEDICAL SOCIETY OF WISCONSIN

September 18, 19 and 20, 1940, Milwaukee

Urologic Indications In Injuries

IN A RECENT survey by Marquardt and Cook, appearing on pages 18 to 24 of this issue, automobile accidents accounted for 70 per cent of all urinary tract injuries, excluding instrumental injuries. The steady rise in the number of automobile and industrial accidents should make each physician who treats injured persons conscious of urinary tract injuries. This is true because of the high mortality that exists in the more serious urinary tract injuries that are overlooked or inadequately treated.

Injuries of the anterior urethra are usually produced by a straddle injury. The patient experiences some pain and there may be ecchymosis at the site of the injured urethra. Almost invariably there is free urethral bleeding and the patient is unable to urinate or voids a few drops of very bloody urine with considerable discomfort. If this occurs urinary extravasation becomes a part of the picture. Usually it is impossible to pass a catheter, but if it is passed and clear urine is obtained from the bladder, the injury is almost certainly localized to the urethra. If passing the catheter is possible, it may be left in place and effectively acts as a splint upon which the urethra can heal.

Ruptured bladder accompanies fractured pelvis in about 5 per cent of the cases. This injury is almost invariably fatal unless treated within twenty-four hours. In this injury the patient is usually unable to urinate or voids but small amounts of bloody urine. Suprapubic tenderness is present immediately and, in late cases, there is evidence of sepsis. If the rupture is intraperitoneal, peritonitis occurs quickly. The ability to urinate may be misleading and, when the diagnosis is doubtful, a cystogram with the bladder well distended is definitely indicated.

Injuries of the ureter are extremely uncommon. They occur primarily in stab or gunshot wounds. Blood is usually present in the urine and urinary extravasation with cellulitis occurs early if the injury is not recognized.

Kidney injuries for the most part are not serious. Whenever the lower ribs are fractured this injury should be considered. If the injury is severe, there is shock. However, most cases are first recognized when the injured individual voids a bloody urine. Intravenous pyelograms are usually inadequate and not of diagnostic value. In doubtful cases, retrograde pyelography often furnishes information vital to the patient's care.

The establishment of a routine type of examination of injured individuals is essential to the early recognition of urinary tract injuries. *Any seriously injured individual should be requested to urinate or else be catheterized on entrance.* If the urine is bloody, an intravenous pyelogram should be done, and if that proves unsatisfactory to establish a diagnosis, a more complete urological investigation should be made. Severe urinary tract injuries carry a mortality of 30 to 40 per cent. Urinary extravasation is responsible for the larger part of this mortality. It is only by the early recognition and adequate treatment of urinary extravasation that this mortality can be reduced. C. R. M.

THE PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association advocates:

1. The establishment of an agency of federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

Care of the Indigent

WITH the onset of the depression years, the "load" of the indigent rose in both numbers and percentages until it passed the point of any possibility of the physician meeting the problem without aid. As we start the year of 1940 we find that of Wisconsin's estimated 2,909,000 population round numbers show that:

175,000 people are receiving direct relief
195,000 people, exclusive of administration employees, are supported by W.P.A. employment
95,000 people are in families receiving one of the three Social Security aids (aid for dependent children, aid for the blind, and old age assistance)

All of these 465,000 (16 per cent of the total population) either have no margin of income over living costs or, in the main, such a slight margin, that illness of any consequence justly entitles them to receive their sickness care through either increased grants for those receiving the pension aids, or when this is insufficient and for those in marginal income groups and on relief, at the hands of the proper relief authorities.

In the December, 1939 issue of the WISCONSIN MEDICAL JOURNAL the laws of Wisconsin relating to the responsibility of the proper governmental officials to furnish relief were concisely and effectively summarized. That summarization was of such excellence as again to meet with the there reprinted commendation of the Attorney General of Wisconsin. Therein it was well stated that there is no "No Man's Land" in the field of poor relief. If the medically indigent is not the responsibility of one relief agency, he is of another.

Responsibility cannot be evaded nor must it be so shifted from point to point as to constitute evasion.

On the face of it, there should be no difficulty in securing the proper governmental aid for the sickness care of the indigent. Factually, there are in some places great and seemingly increasing difficulties.

Of the seventy-one counties of the State, thirty-one handle their relief problems through a unified county administration. In forty other counties these responsibilities devolve for the most part upon elected town officers. (In nine of the forty counties part of the county is on the unit system and part on a group agreement.) In these forty counties the local authorizing officers are sometimes hard to reach in emergencies, sometimes without an understanding of the broad humane intent of the spirit of the law and insistent upon observance of the dead hand of its letter, frequently themselves under criticism for a wholly proper exercise of their power by constituents who view with alarm mounting tax costs, and not infrequently faced with a treasury that is simply and plainly insufficient to meet the needs of the day. In whole or in part the same situation may be found in some county administrations as well and in particular in the northern tier of our counties where state aid is helpful but limited.

As a result, the physician whose patient is entitled to aid finds himself faced with a maze of difficult to intolerable situations. There are the counties that lay down the hard and fast (and illegal) rule that regardless of the nature of the illness, regardless of the number of children in the family, regardless of the limited income, no relief will be extended in any families receiving employment from W.P.A. or perchance only where there are more than two children. There are counties that seek to discharge a legal obligation by hiring one or two physicians to care for the needs among so many hundreds and thousands over such areas that by no stretch of the imagination could such needs be filled by the part-time service of the appointed and generally low salaried men. Nor does this obtain in some counties only. It likewise may be observed in some few cities. There is, furthermore, such lack of understanding as the U. S. Employees' Compensation Commission ruling that injuries of those on W.P.A. employment rolls are cases to be distributed equitably among physicians. They forget that these injuries occur to human beings who may need the services of a certain physician or classes of physicians if they are to receive the care that the very nature of the injury demands. There are the administrators, not content with the fact that the physicians as a whole agree to accept but 50 per cent of their minimum fees in caring for the indigent, who constantly seek further reductions and apparently consider that their efficiency rating depends upon showing that their administration pays the lowest per patient sickness bills. There is the lay administrator or official who, worst of all, presumes to pass upon whether the patient needs as outlined by the physician are or are not real, and thus assumes to be a lay super-physician.

Preventive measures as a rule are not within the realm of relief fund finances. The physician is without power to secure his patient needs for under the law only the patient who is deprived of service has a right at law and that is a right that exists in theory and in law, but not one that the indigent, denied relief that he needs tomorrow, may so exercise so as to obtain timely justice.

This statement of conditions is neither complete on the one hand, nor does it apply in the majority of instances of relief administration on the other hand. It does not state, as any complete statement must, that sometimes, but far less frequently than alleged, there is the physician who is subject to very just criticism.

It is a statement, however, that in many sections physicians as a whole are faced with grave difficulties in securing for their patients the aid that any humane interpretation of the State's relief laws of necessity requires. It is a statement that one of the growing and most important problems of medicine today in furnishing health and sickness services to the people, is the problem of securing any adequate governmental assistance in filling the real needs of the medically indigent. It is a problem that the depression years have gravely accentuated and one that a federal administration failed to solve. (For was it not the Federal Emergency Relief Administration that said federal funds could be used for care of the sick in their homes or in the physician's office, but not if the patient needed to be hospitalized?)

This much is certain,—that the problem best can be handled when a sufficiency of funds are available; when the county medical society is made the contractual authority for the rendition of physicians' services as the laws of 1935 make possible, and when both groups seeking an understanding of the problems of each other display a willingness to meet across the conference table. This willingness has always existed on the part of medicine. Its existence should be made known in every county where the authorizations fail to meet the extent of the problem.

Society Proceedings

Ashland—Bayfield—Iron

The Ashland–Bayfield–Iron County Medical Society met in Ashland on December 11. Dinner was served at 6:30 p. m. and a scientific program presented. Dr. L. R. Gowan of Duluth, Minn., was the guest speaker. He discussed "The Place of Psychiatry in General Practice."

New officers recently elected by the Ashland–Bayfield–Iron County Medical Society for 1940 are:

President—Dr. R. O. Grigsby, Ashland
Vice-President—Dr. C. W. Lockhart, Mellen
Secretary – Treasurer — Dr. F. C. Jacobson, Washburn

Barron—Washburn—Sawyer—Burnett

The Barron–Washburn–Sawyer–Burnett County Medical Society at its November meeting, elected the following officers for 1940:

President—Dr. H. H. Ainsworth, Birchwood
Vice-President—Dr. O. S. Lund, Cumberland
Secretary—Dr. R. W. Adams, Chetek
Delegate—Dr. A. S. White, Rice Lake
Alternate delegate—Dr. R. W. Adams, Chetek
Censor (2 year term)—Dr. C. C. Post, Barron

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society met in Green Bay on December 21. Featuring the meeting were election of officers for 1940, a dinner and a talk by Dr. M. G. Peterman, professor of pediatrics, Marquette University School of Medicine, Milwaukee, on "Immunization in Acute Infectious Diseases."

Columbia—Marquette—Adams

The Columbia–Marquette–Adams County Medical Society met in Columbus on December 12 at St. Mary's Hospital. Dinner was served to the members of the society and its woman's auxiliary at 6:30 p. m. Later in the evening a scientific program was given, Dr. E. L. Sevringhaus. Madison, speaking on "Endocrinology."

Dane

The Dane County Medical Society met on December 12 at the Madison Club, Madison. Following a business session three Madison physicians presented addresses as follows:

Dr. C. F. Burke—What Is New in Medicine?
Dr. A. S. Jackson—What Is New in Surgery?
Dr. O. O. Meyer—The Hemorrhagic Diseases.

Dodge

At 8 p. m. on the evening of Thursday, December 14, the Dodge County Medical Society met at the Deaconess Lutheran Hospital, Beaver Dam. Approximately twenty-five members were present and guests included Dr. J. C. Hassall, Oconomowoc, and Mr. J. G. Crownhart, Secretary of the State Medical Society. Dr. Hassall gave an address on "Common Types of Mental Disease."

Douglas

The Douglas County Medical Society at a recent meeting elected the following physicians, all of Superior, to serve as officers for the ensuing year:

President—Dr. T. J. Doyle
Vice-President—Dr. R. E. Christiansen
Secretary-Treasurer—Dr. Conrad W. Giesen
Censor—Dr. G. J. Hathaway

At its meeting on December 6, the society had as guests Dr. L. R. Gowan of Duluth, Minn., and Mr. George B. Larson, assistant secretary of the State Medical Society. Dr. Gowan spoke on "Epilepsy" and Mr. Larson on "Cooperative Health Plans." Twenty-two members attended the December meeting.

Eau Claire—Dunn—Pepin

The Eau Claire–Dunn–Pepin County Medical Society met on November 27 at the Hotel Eau Claire. On the scientific program, presented after a 6:30 p. m. dinner, Dr. Harold E. Marsh, Madison, discussed "Pneumonia" and Dr. Forrester Raine, Milwaukee, "Phases of Chest Surgery."

The society held its annual Christmas meeting at the Hotel Eau Claire on December 18.

Forest

The Forest County Medical Society has elected officers for 1940 as follows:

President—Dr. O. S. Tenley, Wabeno
Vice-President—Dr. G. W. Ison, Crandon
Secretary-Treasurer—Dr. H. C. Marsh, Crandon

Green Lake—Waushara

The Green Lake–Waushara County Medical Society at its meeting on December 12 at the Whiting Hotel, Berlin, chose some of its officers for 1940. Dr. G. G. Mueller, Princeton, was elected president. Dr. H. C. Koch, Berlin, was elected secretary-treasurer, replacing Dr. A. J. Wiesender, Berlin, who has served the society in that capacity for a period of twenty years. Dr. Harold E. Marsh of the Jackson Clinic, Madison, was the guest speaker on the scientific program. He discussed "Heart Disease."

Iowa

At a meeting in December, the Iowa County Medical Society elected officers for 1940 as follows:

President—Dr. T. A. Hagerup, Dodgeville
Vice-President—Dr. W. P. Hamilton, Dodgeville
Secretary—Dr. H. M. Walker, Dodgeville

Jefferson

The Jefferson County Medical Society met on December 21 at the Jefferson House, Jefferson. The following officers were elected for the coming year:

President—Dr. J. C. Brewer, Jefferson
Vice-President—Dr. Floyd A. Wendt, Johnson Creek
Secretary-Treasurer—Dr. L. H. Gueldner, Fort Atkinson

La Crosse

The La Crosse County Medical Society met on December 12 at the Hotel Stoddard, La Crosse. Dinner was served at 6:30 p. m. and a scientific program given. Dr. T. J. Dry of the Mayo Clinic, Rochester, Minn., was the guest speaker. His subject was "Management of Cardiac Disorders."

Milwaukee

The annual meeting of the Milwaukee County Medical Society was held on December 14 at the Hotel Schroeder in the Crystal Ballroom. Dinner was served at 6 p. m. In the course of the program which followed Dr. Millard Tufts, Milwaukee, outgoing president, outlined the history of the society; Dr. William M. Jermain, Milwaukee, incoming president, discussed the economic aspects of medical practice today; and Dr. James B. Herrick, Rush Medical College, Chicago, delivered an address on "What Not to Do in Heart Disease."

Officers for 1940 were elected as follows:

President-Elect—Dr. T. J. Howard
Secretary—Dr. E. O. Gertenbach
Treasurer—Dr. L. J. Van Hecke
Member, Board of Directors—Dr. Millard Tufts
Board of Censors (two-year terms): Dr. William A. Ryan, Dr. Ulrich Senn
Delegates (1940–1941)—Dr. J. O. Dieterle, Dr. C. W. Eberbach, Dr. Charles Fidler, Dr. R. E. Galasinski, Dr. J. L. Garvey, Dr. L. W. Hipke, Dr. Irwin Schulz

Dr. L. M. Wieder was nominated to fill the unexpired term of Dr. H. J. Gramling, Delegate—1940.

Dr. J. C. Griffith was nominated to fill the unexpired term of Dr. R. E. Fitzgerald, Delegate—1940.

Oconto

The Oconto County Medical Society held a dinner meeting at The Alamo, Stiles, at 6 p. m. Wednesday evening, December 14. There were about fifteen members present. Secretary Crownhart of the State Society was a guest. After dinner a round-table discussion of the relief medical care situation in the county was held, in which the chairman of the county board and the county auditor participated. After this discussion, the two latter guests were excused and an executive session was held. Officers were elected for the year 1940 as follows:

President—Dr. W. C. Watkins, Oconto
Vice-President—Dr. W. R. Berg, Gillett
Secretary—Dr. A. N. Tousignant, Oconto
Treasurer—Dr. R. J. Rogers, Oconto
Delegate—Dr. J. S. Dougherty, Suring
Alternate delegate—Dr. C. R. Kwapy, Oconto
Censors—Dr. G. W. Krahn, Oconto Falls, Dr. R. J. Goggins, Oconto Falls

Pierce

The Pierce–St. Croix County Medical Society met on December 14 in Hudson. Guests included Dr. Elmer L. Sevringhaus, Madison, and Dr. F. E. Butler, Councilor of the Tenth District of the State Medical Society. Dr. Sevringhaus discussed "Endocrine Disorders." About eighteen members of the society attended the meeting.

Polk

The Polk County Medical Society has elected the following officers for the ensuing year:

President—Dr. A. N. Nelson, Clear Lake
Vice-President—Dr. W. B. Cornwall, Amery
Secretary-Treasurer—Dr. G. B. Noyes, Centuria
Censors (3 year term)—Dr. V. C. Kremser, Amery

At the November 16 meeting of the society in Clear Lake, Dr. Norman E. Rud of Minneapolis spoke on "Allergy," and Dr. Ernest R. Anderson of Minneapolis discussed "Urinary Lithiasis," illustrating his remarks with x-ray plates showing stones at various sites in the urinary tract. Twelve members and five guests attended this meeting; they were the guests of Dr. A. N. Nelson.

Dr. L. O. Simenstad was host at the December 14 meeting of the society in Osceola on December 14, attended by thirteen members and six guests. On the scientific program, Dr. William A. O'Brien, Minneapolis, discussed "Anemia" and Dr. Lawrence R. Boies, Minneapolis, spoke on "Some Common Problems in Otolaryngology."

Racine

The Racine County Medical Society met on December 13 in Racine for an all-day meeting, featuring a pathologic conference and the following varied afternoon program:

1:00 p.m. Dr. O. O. Meyer, Madison: "Control Conception of Anemias."

1:45 p.m. Dr. Frank V. Theis, Chicago; "Peripheral Circulatory Diseases."

2:30 p.m. Dr. E. M. Miller, Chicago: "Abdominal Surgery in Children."

3:30 p.m. Dr. Walter C. Alvarez, Rochester, Minn.: "Indigestion."

4:15 p.m. Dr. L. W. Riba, Chicago: "Hemorrhage of the Urinary Tract."

5:00 p.m. Dr. Francis Murphy, Milwaukee: "Obscure Fever and Its Management."

Following dinner at the Meadowbrook Country Club, Racine, Dr. Stephen Gavin, chairman of the Council of the State Medical Society, addressed the group on "Problems of Present Day Social and Economic Trends in Medicine." Other speakers on the evening program were Dr. W. C. Alvarez of Rochester, Minn., and Dr. R. M. Kurten, Racine.

Rock

The Rock County Medical Society met at the Hotel Hilton, Beloit, on December 19 in conjunction with the Rock River Valley Eye, Ear, Nose and Throat Society. Forty-four physicians attended. Among the guests was Mr. George B. Larson, assistant secretary of the State Society who discussed problems of medical care with the Rock county society's medical service committee. Speakers on the scientific program were Dr. George P. Guibor and Mr. Austin Belgard, Chicago, who discussed "Some Interesting Facts about Crossed Eyes" and "Recent Advances in Lens Manufacture."

Washington—Ozaukee

The Washington–Ozaukee County Medical Society met in Kewaskum on December 7. The secretary of the society writes: "First meeting with wives as invited guests—great success." Officers for 1940 were elected as follows:

President—Dr. O. J. Hurth, Cedarburg
Vice-President—Dr. F. W. Lehmann, Hartford
Secretary—Dr. C. H. Kalb, Grafton
Delegate—Dr. J. G. Hoffmann, Hartford
Alternate delegate—Dr. O. J. Hurth, Cedarburg

Dr. Stephen E. Gavin, chairman of the Council of the State Medical Society, gave a talk on the Wagner Health Bill. Dr. George O. Dunker, Milwaukee, presented motion pictures of Germany, Vienna and Italy. Thirty-seven physicians attended the meeting.

Waukesha

The Waukesha County Medical Society held its annual meeting on December 6 at the Waukesha Springs Sanitarium. The following officers were elected for the coming year:

President—Dr. Irene T. Stemper, Oconomowoc
Vice-President—Dr. Griffith Jones, Genesee Depot
Secretary-Treasurer—Dr. J. Francis Wilkinson, Oconomowoc
Delegate—Dr. James C. Hassall
Alternate delegate—Dr. R. E. Davies, Waukesha

Guest speakers at the meeting were Dr. Ralph Sproule, Milwaukee, president-elect of the State Medical Society, and Mr. J. G. Crownhart, secretary of the State Society.

Waupaca

The Waupaca County Medical Society elected officers for the coming year at its meeting in New London on November 21, as follows:

President—Dr. A. M. Christofferson, Waupaca
Vice-President—Dr. H. C. Schmallenberg, New London
Secretary-Treasurer—Dr. J. W. Monsted, New London
Delegate—Dr. J. H. Murphy, Clintonville
Alternate delegate—Dr. R. K. Irvine, Manawa
Censors—Dr. R. K. Irvine, Manawa, Dr. W. F. Wilker, Iola

Winnebago

The Winnebago County Medical Society met at the Valley Inn, Neenah, December 7. Following dinner, served at 6:30 p. m., a scientific program was presented, Dr. A. G. Koehler, Oshkosh, discussing "Subacute Bacterial Endocarditis" and Dr. George Williamson, Neenah, "Coronary Thrombosis and Occlusion."

Wood

The Wood County Medical Society met in Marshfield on December 5. Twenty-seven physicians attended. Dr. L. C. Pomainville, Wisconsin Rapids, spoke on "Aneurysm of the Aorta" and the following papers were presented by Marshfield physicians:

Trigeminal Neuralgia—Dr. E. J. McGinn
Lantern Slide Demonstration of Interesting Eye Conditions—Dr. L. A. Copps
Duhring's Disease—Dr. Stephan Epstein
X-ray Diagnosis and Surgical Treatment of Lesions of the Colon—Dr. R. P. Potter, Dr. P. F. Doege

Problems of relief medical care were discussed by Mr. Reuben Connor, Wood county relief commissioner.

Milwaukee Neuropsychiatric Society

The Milwaukee Neuropsychiatric Society met on December 7 at the Shorewood Hospital Sanitarium. Dr. J. L. Kinsey, Milwaukee, spoke on "Metrazol Shock Therapy" and Dr. W. H. Studley, Milwaukee, "Insulin Shock Therapy." Following these presentations, there was general discussion of results obtained with shock therapy.

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society met on December 12 at the University Club, Milwaukee. Clinical cases were discussed from 6 p. m. to 6:30 p. m. Dinner was then served and later in the evening the following scientific program presented: "Petrositis," by Dr. J. R. Lindsay, Chicago; "Illumination Standardization of the Snellen Chart," by Dr. Hilmar G. Martin, Milwaukee.

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine met on December 19 for a business and scientific meeting. On the scientific program, Dr. Harry Beckman, professor of pharmacology, Marquette University School of Medicine, Milwaukee, discussed "Prophylaxis in Malaria."

News Items and Personals

The Public Works Administration has approved a number of projects for the construction of new buildings or additions to old buildings to be used essentially in the care of the sick.

Grants totaling $1,517,128 were approved for eighteen projects in Wisconsin, to be located in Chippewa Falls, Eau Claire, Green Bay, Kenosha, Madison, Marinette, Menomonie, Oshkosh, Racine, Ripon, Sheboygan, Waukesha, Wausau and Wauwatosa. Most of the projects will be carried out in connection with programs of county asylums, tuberculosis sanatoriums and city hospitals to enlarge or improve existing facilities. The total estimated cost of the eighteen projects is $3,825,980.

—△—

"The Problem of Mistaken Sex," was discussed by *Dr. Ira R. Sisk*, Madison, at the Wisconsin General Hospital staff meeting on December 5. *Dr. John B. Wear*, Madison, at the same meeting spoke on "Surgical Methods of Treating Prostatic Obstruction."

—△—

Dr. Joseph P. Wild has completed postgraduate work at the University of Illinois and has resumed the practice of medicine in Milwaukee at 1729 S. 11th Street, in partnership with *Dr. B. P. Churchill.*

—△—

"I never eat breakfast," a statement often made by young women, is a confession health rules are being disregarded, *Dr. Oscar Lotz*, executive secretary of the Wisconsin Anti-Tuberculosis Association, told students at the Vocational School of Milwaukee, December 7.

—△—

Dr. Peter Midelfart, Eau Claire, has been appointed head of the Eau Claire Civic Music Association.

—△—

Dr. A. I. Rosenberger, Milwaukee psychiatrist, discussed medicolegal definitions of insanity on December 11 in the first of a series of lectures being conducted by the Marquette University Criminal Law Institute.

—△—

"Socialized Medicine, Janesville Style," was the title of a talk given by *Dr. W. A. Munn*, Janesville, before the Rotary Club of that city recently. He explained the Rock county sickness insurance policy being offered on a prepaid basis by the Rock County Medical Society.

—△—

The Lakeside Laboratories, Inc., Milwaukee ampule medications firm, has just issued a grant to Dr. Samuel L. Siegler, obstetrician of Brooklyn, N. Y., to be used in studying the metabolism of progesterone.

Examinations in the basic sciences in 1940 will be held at the times and places given below:

April 6 _____Hotel Loraine, Madison
June 1 _____Hotel Pfister, Milwaukee
September 21 _____Hotel Loraine, Madison
December 7 _____Hotel Pfister, Milwaukee

Information concerning the examinations may be obtained from Prof. Robert N. Bauer, secretary of the Wisconsin State Board of Examiners in the Basic Sciences, 3414 West Wisconsin Avenue, Milwaukee.

—△—

Dr. C. F. Dull, Richland Center, has been reappointed medical advisor of Richland county for the year 1940. The reappointment was made by the Richland County Public Health Committee.

—△—

The University of Wisconsin Medical Society on December 14 in the Service Memorial Institute Building, Madison, had as its guest speaker Dr. A. U. Desjardins of The Mayo Clinic, Rochester, Minnesota. Dr. Desjardins discussed the usefulness of radiation therapy in checking inflammatory diseases.

—△—

Dr. John O'D. McCabe has announced the opening of his office at 208 East Wisconsin Avenue, Milwaukee. He will limit his practice to orthopedic surgery.

—△—

Members of the Cancer Committee of the State Medical Society of Wisconsin met in Madison on December 3 to plan work for 1940 in cancer prevention and control. *Dr. Charles Fidler*, Milwaukee, and *Dr. D. J. Twohig*, Fond du Lac, were elected to fill posts on the administrative executive committee of the Cancer Committee; a subcommittee needed because of the volume of the Cancer Committee's activities. *Dr. Fernan-Nunez*, Milwaukee, chairman of the Cancer Committee, is automatically a member of the administrative executive committee.

—△—

Dr. A. M. Christofferson, Waupaca, was appointed coroner of Waupaca county by Gov. Julius P. Heil, December 8, to fill the unexpired term of the late Dr. John C. Johnson, Ogdensburg, ending January 6, 1941.

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Dr. Marvin Wright, a 1936 graduate of the University of Iowa College of Medicine and for two years in practice in Newton, Iowa, has opened an office for the general practice of medicine in Rhinelander.

Dr. Eben J. Carey, Milwaukee, sounded the following warning at a meeting of the Fond du Lac Rotary Club, December 4:

"The politician is about to advocate more governmental paternalism and the false, suicidal doctrine that the 'state' can provide a service and a security that the people cannot otherwise obtain.

"The regimentation of doctors of medicine and dentistry will lead to disintegration and ill-health. Medical and dental servants under state control will either be all slave or half slave and half free. The historic statement of President Lincoln, 'No state can survive half slave half free,' applies with equal force.

"Regimentation places a brake on service and progress. Regimentation inevitably stifles initiative and starts degeneration of human activities. The advocates of state medicine have carried on a ruthless attack on the independent health servants of the public during the last two years. The sole purpose of the politician has been to gain political advantage by control of dentistry, pharmacy, medicine, medical practice, and hospitalization by government.

"To gain public support for state medicine it was necessary to undermine the confidence of the people in the physician. A malignant campaign to discredit the practicing physician therefore has been carried out."

Predicting that a new health bill will be introduced in the next Congress and that public health will be a major consideration in the next presidential election, Dr. Carey gave the following reasons for the unwillingness of physicians to aid in the passage of compulsory sickness insurance bills:

"1. The accompanying complicated bureaucratic system has no place in a democratic state.

"2. It would undoubtedly set up a far-reaching tax system with great increase in the cost of government.

"3. The burden of the system is distributed over the low income class, which is least able to bear it.

"4. Diagnosis and treatment are mechanical and superficial.

"5. Medical care for the indigent is omitted, and the problem of serious and prolonged illness is not solved.

"6. The control over medical service is placed in the hands of unqualified non-medical individuals and organizations.

"7. Such a system of medical care would lend itself to political control and manipulation.

"Dentistry, as a part of the complete health service of the public, should be included in all deliberations for the delivery of dental service and cooperate with medicine."

He then called attention to the health platform advocated by the American Medical Association (see page 37 of this issue).

CHIROPRACTOR BUYS THE SPA

The Spa, historic Waukesha health institution, has been sold to an East Troy, Wisconsin, chiropractor and his associate. It will be converted into a chiropractic clinic.

Dr. H. H. Christensen, Wausau, lectured November 21 on the latest developments in thoracic surgery at the meeting of the Eighth District of the Wisconsin State Nurses' Association at Mt. View Sanatorium, Wausau. After the program, the nurses were conducted through the new Dr. Lee Willard Memorial Preventorium recently opened at Mt. View Sanatorium.

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Dr. James A. Jackson, Madison, traveled to California by airplane recently to speak before three medical groups. On December 13 he addressed 200 members of the Los Angeles Surgical Society on "Open Reduction Treatment of Fractures," illustrating his remarks with colored motion pictures. On December 16 at the annual meeting of the Western Surgical Society he discussed "Complete Gastrectomy for Linitis Plastica," citing cases in which this treatment had been successful. On December 17 he again presented the lecture on open reduction treatment of fractures, this time before 800 members of the Alumni Association of the College of Medical Evangelists.

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Dr. A. B. Schwartz, Milwaukee, discussed the old proverb, "Man is What He Eats," at the annual convention of the Wisconsin Milk Dealers' Association held at the Schroeder Hotel, Milwaukee, in December.

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Drs. R. L. Cowles, W. P. Tippet and J. W. Vieaux, Green Bay, assisted in presenting lectures on sex problems in marriage, sponsored by the Green Bay Y.M.C.A. adult program committee, December 7, 12 and 19.

—△—

Dr. Dexter Witte, Milwaukee, cautioned the members of the Practical Club, Waukesha, December 5, against making medicine "a part of the spoils of politics under the name of socialized medicine."

—△—

Drs. H. K. B. Allebach and J. L. Armbruster have not left Milwaukee and taken up permanent residence in Elkhorn as a news item in the October, 1939, issue of The Journal indicated. The two doctors still maintain their respective positions in Milwaukee but go one afternoon each week to visit the Walworth County Hospital in Elkhorn where they read x-ray films and make pathologic reports on removed tissue.

Louis Warfield Memorial Lecture, January 23.—The Milwaukee Internists Club, the Wisconsin Anti-Tuberculosis Association and the Milwaukee Academy of Medicine will sponsor a Louis Warfield Memorial Lecture on January 23. The lecture, "Problems and Practical Value of Constitutional Pathology," will be delivered by Dr. Julius Bauer. The meeting will be an informal one. Members of the medical profession throughout the State are cordially invited to attend.

—△—

Second Annual Congress on Industrial Health. January 15–16.—The second annual congress on industrial health, sponsored by the Council on Industrial Health of the American Medical Association, will be held in the Palmer House, Chicago, January 15–16, 1940. *Dr. Stanley J. Seeger*, Milwaukee, who is chairman of the Council on Industrial Health, will preside over the sessions on Monday morning, January 15, and present the report of the Council.

Mr. Harry A. Nelson, director of workmen's compensation, Industrial Commission of Wisconsin, Madison, will discuss "The Wisconsin Plan for Physical Examinations in Industry," and Dr. Paul A. Brehm of the State Board of Health, Madison, will speak on "Scope and Methods of Industrial Physical Examinations in the Wisconsin Plan."

—△—

International College of Surgeons to Convene.—The United States Chapter of the International College of Surgeons will hold its fourth annual assembly, February 11–14, 1940, in Venice, Florida. In addition to prominent American speakers, professors of surgery from Brazil, Canada, Cuba, Mexico, and Turkey will lecture. Scientific and technical exhibits will be displayed in the patio of the Florida Medical Center. A well-rounded social program has been planned for the visiting surgeons, their wives, and guests.

Any information, including details regarding the presentation of scientific papers or exhibits, may be obtained from Dr. Charles H. Arnold, secretary to the scientific assembly, Terminal Building, Lincoln, Nebraska.

Among the scheduled speakers are Dr. Temple Fay, professor of neurosurgery of Temple University, Philadelphia, who will describe the results of his new refrigeration treatment for malignancy which has aroused world-wide interest; Dr. Bradley Patten, director of the department of anatomy, University of Michigan, who will show motion pictures and electrocardiographs of the first heart beats and the beginning of the circulation in living embryos; Drs. Paul T. Butler and Eugene Maier of Florida who will describe recent advances in therapy by the use of snake venoms; and *Dr. William Carson*, Milwaukee, who will speak on retroperitoneal tumors.

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Lippitt Memorial Lecture, January 19.—The fifth Lippitt memorial lecture at Marquette University Medical School auditorium will be given January 19 at 4:30 p. m. by Dr. Harry Goldblatt, professor of experimental pathology at Western Reserve University, Cleveland. Dr. Goldblatt will speak on experimental observations of high blood pressure.

—△—

Midwestern Forum on Allergy.—The second annual conference of the Midwestern Forum on Allergy will be held January 13–14, 1940, in the Palmer House, Chicago. Specialists from Illinois, Michigan, Minnesota, Missouri, Ohio, and Wisconsin will take part in the two-day program. Wisconsin physicians scheduled to appear on the program are *Dr. Theodore L. Squier*, Milwaukee, and *Dr. Theron G. Randolph*, Milwaukee.

The *Advisory Committee on Voluntary Sickness Insurance* of the State Medical Society met in Watertown on November 21 at the Carlton Hotel. Shown in the picture above are *Dr. Robert W. Blumenthal*, Milwaukee, chairman of the committee (right) and *Dr. C. D. Neidhold*, Appleton (left). *Dr. Wellwood Nesbit*, Madison, third member of the committee, was unable to attend the meeting.

MARRIAGES

Dr. A. G. Seelman, Milwaukee, and Miss Mary Miller, Milwaukee, on December 2.

BIRTHS

A son, Robert Arthur, to Dr. and Mrs. W. T. Becker, Milwaukee, on December 11.

A daughter, Diane Lee, to Dr. and Mrs. L. L. Bensman, Milwaukee, on November 11.

A son, Wilen Charles, to Dr. and Mrs. O. H. Anderson, Plum City, on October 23.

A daughter, Frances Ann, to Dr. and Mrs. F. A. Kretlow, Milwaukee, on November 29.

A daughter to Dr. and Mrs. E. T. Hougen, Oostburg, on December 4.

1940

The 17th

consecutive year of advertising

in the

Wisconsin Medical

Journal

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DEATHS

Dr. R. E. Mitchell, Eau Claire physician and surgeon, died suddenly at his home of coronary occlusion on December 12, 1939. He had been in good health and actively participated in the regular monthly staff meeting of the Luther Hospital of Eau Claire during the evening of December 11.

Dr. Mitchell, who had practiced in Eau Claire since 1911, was born at Porter's Mills near that city in 1876. He was graduated from the University of Minnesota College of Homeopathic Medicine and Surgery, Minneapolis, in 1901. Following internship in the Metropolitan Hospital, New York City, he spent nine years as staff physician in the Middletown State Hospital, Middletown, N. Y. During his service in the latter institution he became interested in the application of mental hygiene to the general practice of medicine. At a meeting of the Eau Claire–Dunn–Pepin County Medical Society in 1938, Dr. Mitchell presented a paper on this subject which came to the attention of Dr. A. W. Bryan, Madison, chairman of the Committee on Mental Hygiene and Institutional Care of the State Medical Society of Wisconsin. Impressed by its frankness and simplicity of expression, Dr. Bryan obtained a copy of the paper for submission to the medical editor of the Wisconsin Medical Journal. The paper, "Psychiatric Problems of the General Practitioner," which appeared in the May, 1939, issue of The Journal, pages 385–388, closed with the following question and declaration:

"Are we as physicians going to miss our great opportunity in the field of psychiatric medicine or are we going to continue to give up a part of our heritage as we have in the past,—some of it to quacks and charlatans? It seems to me our people never needed intelligent supervision so badly as right now. Brains are needed and so is honest effort. We can furnish both if we want to, and *it is our job to furnish them.*"

Dr. Mitchell was a man of wide interests and did not confine his energies to the practice of medicine alone. He was much interested in traumatic surgery as a result of experience with accidents in the logging industry. He was concerned with the tuberculosis problem and was for many years a director of the Wisconsin Anti-Tuberculosis Association. He was concerned with maternal and child welfare, especially in the under privileged groups, and was largely instrumental in making available proper hospital facilities for obstetric patients in Eau Claire. More recently he was much interested in the wider application of medical service for indigent and low income groups but strongly against political or bureaucratic governmental interference in making these services available. He was a board member of the Family Service and Central Council of Social Agencies of Eau Claire.

Dr. Mitchell was a member of the Eau Claire–Dunn–Pepin County Medical Society and at intervals over a period of years served that society as secretary, president, and delegate. He was a member of the State Medical Society of Wisconsin, his membership dating back to 1912. Positions held by Dr. Mitchell in the State Society included that of Councilor from the Tenth District (1922–1927) and membership on the Committee on Mental Hygiene and Institutional Care. He was a Fellow of the American Medical Association and a member of the American Psychiatric Association.

He is survived by his widow, two daughters, Marjorie and Doris, and a son, Dr. Mancel T. Mitchell of Eau Claire.

Dr. J. Paul Reinhardt, Fountain City, died on November 12 of a heart ailment. He had been in ill health for about one year.

Dr. Reinhardt was born in 1869. Before beginning the study of medicine, he was graduated in pharmacy and worked in a drug store in Fountain City for several years. He received his degree in medicine from the Bellevue Hospital Medical College, New York, in 1892, and supplemented his studies there by courses at the University of Vermont. In 1894 he returned to Fountain City where he was active in civic and medical circles until illness forced him to retire.

From 1918 to 1928 and from 1934 to 1938, Dr. Reinhardt was mayor of Fountain City. He is given great credit for his economy in administration and for keeping the city on a "pay-as-you-go" basis.

Dr. Reinhardt was a member of the Trempealeau–Jackson–Buffalo County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow and four daughters.

Dr. Emil Tompach, Racine, died on November 25 after a long illness which began several years ago with a fractured hip. He was seventy years old.

Dr. Tompach was born in Bohemia. In 1885 he came to the United States and later entered Rush Medical College in Chicago. Following his graduation in 1894, he practiced medicine in Kewaunee and Kellnersville, Wisconsin. In 1900 he moved to Racine and remained in practice there until ill health caused his retirement.

The doctor served during the World War on the Racine Advisory Board and as examining physician. He was a member of the Racine County Medical Society and the State Medical Society of Wisconsin. He was a Fellow of the American Medical Association.

As The Journal goes to press, word is received of the death of **Dr. William Snow Miller,** Madison, emeritus professor of anatomy at the University of Wisconsin Medical School, and medical historian. Dr. Miller's obituary will appear in the February, 1940, issue of The Journal.

A concerted plan of attack on—

PNEUMONIA

THE OUTLOOK FOR THE TREATMENT OF PNEUMONIA, this Winter, is better than ever. DR. RUSSELL L. CECIL, (discussion of "Sulfapyridine in the Treatment of Pneumonia"—PLUMMER, N. and ENSWORTH, H. K., J. A. M. A., Nov. 18, 1939, 113:1853) summarizes it very aptly:

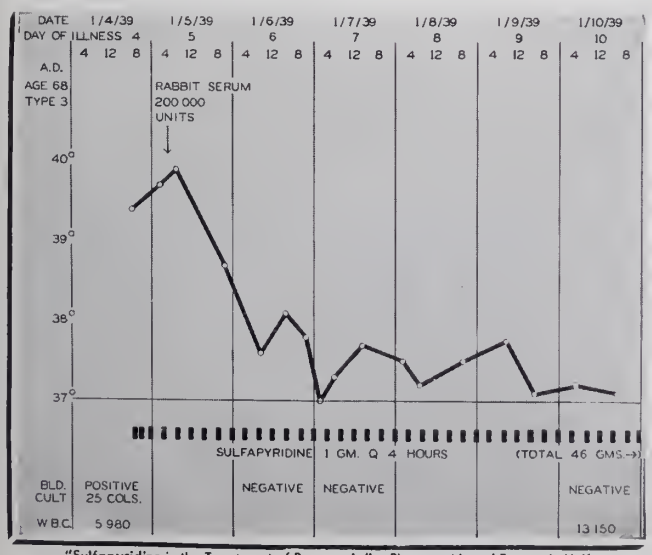
> "... We have a double-barreled gun for the treatment of pneumonia, and whether we need both barrels or only one remains to be seen. DR. BULLOWA and DR. MACLEOD expressed it very well when they said that serum fortifies the pneumonia patient; sulfapyridine injures the pneumococcus. For the present we must keep our serum handy and use it in severe cases along with sulfapyridine, and we must continue to type our pneumonias in order that we may get all the better oriented with regard to this new form of therapy."

Unless either agent is specifically contraindicated, the combination of drug and serum should always be employed when:

1 — treatment is begun after the third day;
2 — two or more lobes are involved;
3 — the patient is over 40;
4 — the patient is pregnant or in the first week of the puerperium;
5 — blood culture is positive.

When used simultaneously with drug, smaller amounts of serum may be employed.

Information on sulfapyridine or pneumonia serum on request.



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CORRESPONDENCE

A LETTER TO THE EDITOR

The Editor,
Wisconsin Medical Journal,
Madison, Wisconsin.

Dear Sir: Our president—Dr. R. G. Arveson—has asked for a "democratic discussion" of matters pertinent to the "good of the order." He further states that "Ours is a democratic institution." *Is it?* I had the honor and privilege of serving as Councilor for the Seventh Councilor District for two consecutive terms—six years (1929–1935). At the end of that time I resigned my office and the following is *part* of a letter which I then addressed to my fellow members of the district:

"My experiences as your Councilor have been most gratifying and rewarding. In my associates of the Council I have found as loyal a group of friendly comrades as could fall to the lot of any man. I shall leave the office with a few rather definite impressions and convictions. Here are two or three of them—

* * *

"Let no one think that the deliberations of the Council are 'cut and dried.' I have never sat in a deliberative body where problems and programs were discussed and cussed with more freedom of thought or sharper divergence of opinion. Not one of your Councilors but has given unstintingly of his time and talent. Theirs is largely a labor of love. The personnel of the Council is excellent. It always *has* been. *But* . . . the method by which we elect our Councilors is—in my opinion—about as unrepresentative as the human mind could devise. Theoretically it is democratic. In actual practice it is anything BUT! If you do not believe *that*, then attend the first meeting of the House of Delegates, next fall, and watch the method work!! While I cannot see how any finer quality of Councilors could be elected under any *other* method, I feel certain that, if our Society wishes to preserve internal as well as external harmony, some better method must be found. We have the genius to find it. Surely every Councilor would prize his election far more highly if he could feel that every member in his district had had a 'direct' voice in it. And can anyone tell us why Councilors should not be elected by the members of their own district and by them *only*? Why should the members of the Seventh District have any voice in the election of a Councilor for any other district? Or vice versa? Let each Councilor District elect its own Councilor; and do that before the annual meeting of the Society? The House of Delegates needs its time for other matters than the election of Councilors. With Councilor material so very abundant in every district, it seems to me that no Councilor should serve his district for more than two consecutive terms. Why not distribute the honor and the work more frequently? In so doing I believe we would discover and develop new talent. And the discovery and development of new talent among our members *should* be one of the foremost of our objectives."

With malice toward none—and with no axe to grind—"them's still my sentiments."

SPENCER D. BEEBE, M.D.,
Sparta, Wisconsin.

THE BLUE BOOK

Mr. J. G. Crownhart, December 11, 1939.
Wisconsin Medical Journal,
Madison, Wisconsin.

Dear Mr. Crownhart: My sincerest thanks, congratulations and best wishes to whoever was responsible for the last number of The Journal. It is a Blue Book that *is a Blue Book!*

Sincerely
ERNEST A. PETZKE, M.D.,
Hixton, Wisconsin.

FROM ARKANSAS

ARKANSAS MEDICAL SOCIETY
Fort Smith, Arkansas

December 14, 1939.

Mr. J. G. Crownhart, Secretary,
State Medical Society of Wisconsin,
917 Tenney Building,
Madison, Wisconsin.

Dear George: Just to express my admiration for the wonderful December issue of the WISCONSIN MEDICAL JOURNAL and for the effort put forth.

Best wishes for a happy holiday season.

Sincerely,
W. R. BROOKSHER,
Secretary.

FROM MR. WIPRUD

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA,
Washington

December 15, 1939.

Mr. J. G. Crownhart, Secretary,
State Medical Society of Wisconsin,
Madison, Wisconsin.

Dear George: The December issue of the WISCONSIN MEDICAL JOURNAL came to my desk a few days ago. I think this is one of the finest issues of a state medical journal that I have ever seen. I certainly want to congratulate you upon it. Members of the State Medical Society of Wisconsin should be deeply appreciative of the abundance of valuable information contained in this number.

Cordially yours,
THEODORE WIPRUD,
Secretary.

CORRESPONDENCE—Continued

"A GEM . . . "

December 12, 1939.

Mr. J. G. Crownhart,
Room 917 Tenney Building,
Madison, Wisconsin.

Dear Mr. Crownhart: Your December blue book is a gem!

I think this is the best number the Journal has ever published!

Very truly yours,
M. D. Bird, M. D.,
Marinette, Wisconsin.

SOCIETY RECORDS

New Members

M. J. Lustok, 536 West Wisconsin Avenue, Milwaukee.

G. A. Kriz, 806 North Eleventh Street, Milwaukee.

J. H. Spearing, Jr., 2702 North Third Street, Milwaukee.

T. G. Randolph, 425 East Wisconsin Avenue, Milwaukee.

B. B. Schoenkerman, 606 West Wisconsin Avenue, Milwaukee.

I. B. Love, 1930 East North Avenue, Milwaukee.

E. C. Kocovsky, 3531 West Lisbon Avenue, Milwaukee.

G. R. Curless, Public Service Building, Beloit.

Helen W. Bane, 210 Goodwin Block, Beloit.

R. F. Schoen, Beaver Dam.

Changes in Address

R. R. Rath, Granton, to 918 East Lime Street, Lakeland, Florida.

E. J. Schneeberger, Hillsboro, to Hoeschler Building, La Crosse.

J. W. Ehmer, Wausaukee, to Mohawk Camp, Crivitz.

J. P. Wild, Chicago, to 1729 South Eleventh Street, Milwaukee.

OFFICIAL NOTICE OF PROPOSED CHANGE IN CONSTITUTION

The following proposed amendment to Section 2, Article IX of the Constitution of the State Medical Society of Wisconsin—submitted at the 1939 session of the House of Delegates of the State Society by the Jefferson County Medical Society through Dr. W. S. Waite of Watertown, delegate—will be voted on by the House at its September 1940 session in Milwaukee.

Amendment Relative to Elections

Section 2. The President, President Elect, Speaker and Vice-Speaker shall be elected by the House of Delegates. The Secretary and Treasurer shall be elected by the Council. Councilors shall be elected at a meeting of their respective district societies held within the twelve months' period prior to the annual meeting of the State Society at which the term of Councilor expires. Certification of such election, signed by the President and Secretary of the councilor district society, shall be placed in the hands of the Secretary of the State Medical Society prior to the annual meeting of the Society in the year in which the term of such Councilor expires. In the event a councilor district fails so to certify its election, the election for Councilor of such district shall be by the House of Delegates. Notices of election of a Councilor in a district shall be incorporated in a mailed notice to the members of the district at least seven days before the meeting at which the election is to be held.

Election, where more than one nomination is received, shall be by ballot and a majority of votes cast shall be necessary to elect. Each candidate for Councilor must be a resident of the district which it is proposed to represent and no person known to have solicited votes for or sought the office of Councilor shall be eligible for the current election. Other procedure essential to the election shall be governed by Robert's Rules of Order.

The officers, except the Councilors, shall be elected annually. The terms of Councilors shall be for three years, and all officers shall serve until their successors are elected and installed. There shall be elected one Councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional Councilor for each additional 250 members or major fraction thereof. As nearly as possible, one-third of the members of the Council shall be elected each year.

The President-Elect shall automatically succeed the office of President at the conclusion of his one-year term of President-Elect.

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"The Greatest Assistance . . ."

By R. G. ARVESON, M. D.
Frederic
President of the State Medical Society of Wisconsin

THE Woman's Auxiliary to the State Medical Society of Wisconsin began some twelve years ago. It has grown rapidly with the result that today there are twenty-seven component societies with a total membership of about 1,200. Such growth speaks well for the organizing ability of those who guided the Auxiliary through its infant years.

Webster says of the word *auxiliary,* "Conferring help or aid; assistant." How can the Auxiliary of the State Medical Society be an *auxiliary* in the true sense of the word? That is what I want to discuss.

The greatest assistance that can be given the State Medical Society today by the Woman's Auxiliary is in the intelligent dissemination of facts about the doctor and the medical profession that he himself cannot with good grace make known or is reluctant to discuss. Medicine in America has been subject to violent attacks for the last several years. Attempts are still being made by those in high places to regiment the profession; in fact a steady and studied attempt is being made to level everything and everybody in the United States. Many have enjoyed the prospect of seeing this done.

There has been a great hue and cry in the last few years for *free* things and many of our citizens, whole droves of them, have not been backward in stepping up to get what they considered their proper share. We all have seen people who accepted gifts from others over a long period of time and at last became so indebted to the giver that, in a way, they could not call their lives their own. This is my idea of what is occurring nationally today.

Every time great masses of people accept outright gifts from the government, they must, in so doing, surrender some of their liberties. It has been prophesied by many that in time we are going to have in this country a peasantry comparable to that of Europe and, at the same time, a few of great wealth and great power. Some of us who believe we still think sanely on the subject are opposed to this prophesy, but we are put to the question—the wondering, if you please—as to the whereabouts of the stout hearts and the stout souls who must have inherited some of the spirit of our forbears of the American Revolution. Why do they not come forward now in larger numbers to protect that greatest of all our possessions—our liberty? Many forget that we of the medical profession are a part of society and that the leveling of us and the taking away of our liberty means just the taking out of another brick in the common wall of all.

It seems to me that in her many contacts, the doctor's wife can carry the true story of medicine to her associates and her clubs. But I asked a doctor's wife the other evening if

A Happy And A Lovely New Year

(To the Ladies)

To you, our patrons, we extend every good wish for the New Year. We thank you for your patronage and resolve to merit its continuance throughout the years to come.

We sincerely hope that during the New Year those of you who are introduced to Luzier products through the medium of this State Journal will afford us an opportunity to merit your patronage.

May 1940 be the loveliest year of your life.

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she stood up in her club and defended medicine when it was attacked, and she replied she did not. She said she was afraid.

Afraid of what? Medicine is one of the oldest, most respected of professions. It is directly responsible for a remarkable increase in the length of life, for the health and growth of cities, for untold happiness. Members of the medical profession give millions yearly in free service; they have made the United States the leader in medicine. Wisconsin physicians have made Wisconsin one of the three leading states in health accomplishments in the Union.

In view of all this, medicine would seem to require no defense, but it does because an insidious propaganda is being spread daily in women's clubs and other groups to undermine it. In the work of combating such propaganda by educating the public, it seems to me the Auxiliary can be of inestimable value.

Medical men for a time were concerned with what would happen to medicine. To a very great extent they have forgotten that and intelligent men are concerned with what regimentation will do to society in general. If either medicine or society falls, both will —for they are inseparable.

I am in favor of the program as carried on now by the Auxiliary, very much in favor of it, but there are deeper things at stake than this program. There are things at stake that I make bold to say the Auxiliary better than any other group can safeguard—the integrity of the medical profession and the health of the people of Wisconsin.

There are 1,200 members in the Auxiliary; there should be at least 2,000. Think what 2,000 women could do collectively in this state in the matter of educating the public as to our true position. But first there must be missionary work among present members. Each must know the story and the facts.

Do you remember the enchantment Douglas Jerrold wove about a hat peg? Do you recall that at the christening the child was given great gifts of diamonds, pearls and laces and when the fairy godmother came it was expected she would eclipse these gifts with the magnificence of her dowry but she gave the child simply a hat peg? All wondered what good could come of that. The boy grew to be a man. In wild pursuits his riches were wasted and at last he came home and hung his hat on that peg. And while his hat was hanging there peace and plenty and order and affection sprang up in his home; the hat peg was indeed the talisman of his life. And so then if an apology is needed, I apologize for the allusion—because the State Medical Society holds its Auxiliary as its talisman and its hat peg.

Program—1940

By MRS. J. C. HASSALL
Oconomowoc

IN CONSIDERING programs for county auxiliaries, it is difficult to suggest projects of interest to every auxiliary. Manifestly, those which could be carried out in the larger cities would be neither feasible nor appropriate for the smaller, outlying districts. The program outlined by the program committee of the Woman's Auxiliary to the American Medical Association (and I shall quote liberally from its Bulletin) gives three chief objectives desired by the national organization: The attraction of new members; an increase in attendance at each meeting; and the stimulation of interest in the educational work as suggested by the various county, state and national medical societies. These objectives may be attained by adopting a program to include activities applicable to local needs, by stressing the projects suggested by the medical societies, and by striving for the active participation of as many members as possible.

Some of the more important projects suggested by the national program committee are: An active campaign to increase the sale and distribution of the publication HYGEIA,

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an active year's work in public relations, and more consideration of the social side of your organization.

The national program committee suggests that the secretary and president of the county medical society be invited to address the auxiliary annually at its first meeting. This will make the individual members conscious of their parent organization, but, of greater importance, it will serve to make the medical organization more aware of the service possibilities inherent in the Woman's Auxiliary.

The national program committee further suggests that all committee chairmen report on their activities at each meeting, thus making the individual members more alert to auxiliary interests. "Committee chairmen not called upon to report periodically soon have nothing to report." The president should allot time and suggest members to open the discussion following most presentations.

Further suggestions for auxiliary work are: Publicize to outside groups, as well as to auxiliary members, the regular radio program "Your Health" sponsored by the American Medical Association; spread widely the use of the instructive pamphlets published by the American Medical Association; compile and present as essays some of the facts concerning the development of local and state public health work, which were initiated largely by the organized medical profession. Representative committees of our State Medical Society led the educational endeavors in the State among physicians and the public alike, concerning cancer control, maternal and child welfare, appendicitis mortality, and so forth, long before federal social security funds entered the field through state health departments.

Use the allotted space in the WISCONSIN MEDICAL JOURNAL, and report regularly all meetings, as well as all other auxiliary activities. In each county there are numerous health problems. The auxiliary should study these and be ready to assist in their solution.

The program chairman of each county auxiliary should read to the members the suggestions submitted by your state program committee, and when the program for the year has been determined she should send an outline to the state program chairman. Your willing response to the program chairman's requests that you take part in programs, discussions, and so forth, means much to her. It is a difficult task to plan programs which will be of interest and value to as many members as possible, and it is only by the live interest and active participation of all members that the auxiliary can best serve its purpose.

A Message From the Auxiliary President

To the Members of the Auxiliary:

Christmas has come and gone and with it carols, candles, bells, feasting and gifts. Speaking of gifts, the most precious of all, Good Health, is something many of us enjoy, many yearn for and sometimes acquire, and many go without. Those of us who have it, take it for granted—those who do not, prefer it to all other things. It is a highly personal matter.

The medical profession and its auxiliaries think of the health of the community, state and nation. The health of the people of Wisconsin, we all know, ranks high, and we as an auxiliary to the State Medical Society are anxious to retain this enviable position. In the past considerable work has been done; let us do as much this year and more if possible. It can be done by studying the program which Mrs. J. C. Hassall, our state program chairman, has submitted, reading carefully her letter to you during the year and making good use of the list of speakers available through the committees on program and public relations.

During November it was my pleasure to attend the meeting of the national board at the Palmer House in Chicago. It is always inspiring to attend such a meeting. One realizes the vast amount of work done by the women in attendance, especially officers and chairmen of standing committees. As plans were read the earnestness of the women become more and more apparent. Each one had her story to tell, not only of the work which she had put forth but also of the experiences that had come to her in carrying out her program. It is a full-time job, the services are willingly given, and the rewards are good results.

Going into session at 9:30 a. m., stopping only long enough for luncheon and then returning to work, we heard reports from state presidents of work being carried on all over the country. In the exchange of ideas we all profited from the experiences of others. It made us want to do better on our return home; the goal is distant but we are on our way.

One state president told of a public relations meeting that proved to be a great success. After a month of planning the work with plenty of publicity, they requested that questions be brought to the meet-

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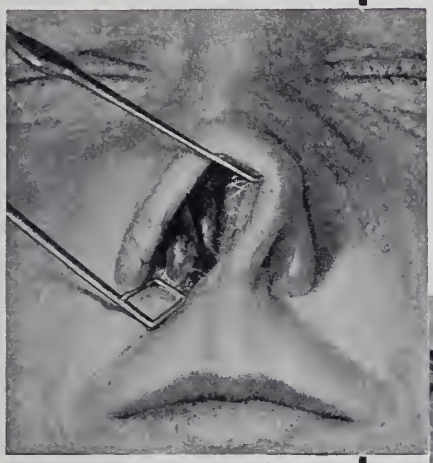


Fig. 1—Time 2:15 P.M. Before treatment.

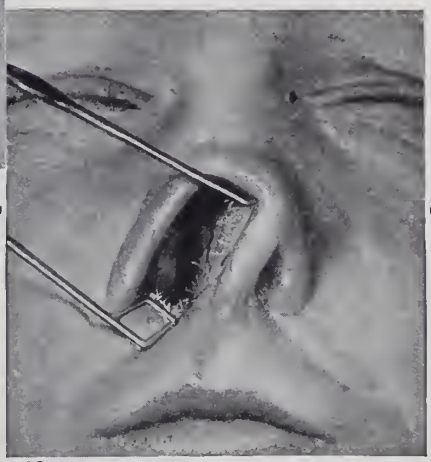
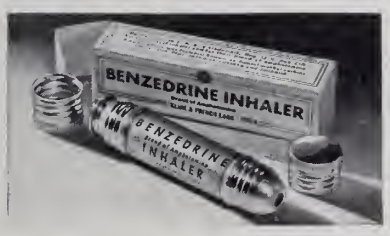


Fig. 2—Time 2:22 P. M. After using 'Benzedrine Inhaler'.



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ing. On the night in question a goodly crowd of some four or five hundred gathered. Seated on the stage were ten doctors well-qualified to handle the discussion; many of these questions were on the Wagner Health Bill. I could not help but detect a sparkle in the eyes of the woman who read this report. It was her idea of a real public relations meeting and I am sure all present agreed with her.

The national historian produced a neatly bound book of last year's activities in the state auxiliaries. This was most interesting. She hopes to add another volume with the help of the present state historians. Many other interesting things came up, and when our day was finished late in the afternoon we all felt that the trip was well worth while.

It was a busy week for our national president, Mrs. R. K. Packard. Conferences, committee meetings, some of them lasting until late at night, and a visit to the medical exhibit at the Museum of Science and Industry filled her days. Now she is to have a month's vacation in California. It is a well-earned vacation.

Mrs. Packard told us of the interesting plans for the national convention to be held from June 10 to 14 in New York City. With the fair held over for another year and all that the city has to offer, I hope many from Wisconsin will be making early reservations. It will be a real opportunity to meet old friends and greet new ones.

Mrs. F. W. Pope,
President.

Columbia—Marquette—Adams

Mrs. J. H. Houghton of Wisconsin Dells, newly appointed press and publicity chairman of the Woman's Auxiliary to the Columbia–Marquette–Adams County Medical Society, has reported the October and November meetings as follows:

The members of the auxiliary met with the members of the Columbia–Marquette–Adams County Medical Society for dinner on Tuesday, October 17, at the Raulf Hotel, Portage. Mrs. H. M. Caldwell of Columbus gave a report on the state convention held in Milwaukee in September. The following slate of officers presented by the nominating committee was accepted:

President-Elect—Mrs. C. J. Radl, Wisconsin Dells
Secretary—Mrs. J. H. Houghton, Wisconsin Dells
Treasurer—Mrs. H. E. Gillette, Pardeeville

The meeting was then turned over to the incoming president, Mrs. L. V. McNamara of Montello, who appointed the following chairmen:

Program—Mrs. C. W. Henney, Portage
Public Relations—Mrs. R. B. Dryer, Poynette
Press and Publicity—Mrs. J. H. Houghton, Wisconsin Dells
Hygeia—Mrs. H. M. Caldwell, Columbus
Social—Mrs. E. F. Tierney, Portage
Membership and Organization—Mrs. J. W. MacGregor, Portage
Archives and History—Mrs. H. E. Gillette, Pardeeville
Sunshine—Mrs. J. P. Harkins, Portage

The November 21 meeting of the auxiliary was also held in conjunction with that of the members of the county medical society, at the Pardeeville Library. Following a business meeting at the home of Mrs. H. E. Gillette, Mrs. J. W. MacGregor read "The Doctor's Wife" by Dr. Rock Sleyster, and a social hour followed.

Dane

About forty members of the Woman's Auxiliary to the Dane County Medical Society met on November 14 at the home of Mrs. C. R. Bardeen of Madison. A one o'clock luncheon was served. The assisting hostesses were Mrs. G. H. Ewell, Mrs. S. A. McCormick, Mrs. K. B. McDonough, Mrs. D. C. Atwood, and Mrs. Milton Trautmann. Mrs. W. H. Krehl, president of the auxiliary, presided at the short business meeting which followed the luncheon. Plans were discussed to donate a sum of money to the loan closet for the purchase of layettes. It was also proposed that each member bring a small gift to the December meeting, to be given to the county nurse for needy children. Following the business meeting a very interesting talk was given by Mrs. Irma Williams, county nurse, on the needs of the loan fund closet.

Fond du Lac

Meeting for dinner at 6:30 p. m. on Thursday, November 14, at the Hotel Retlaw, the Woman's Auxiliary to the Fond du Lac County Medical Society had as guests Miss Vivian Sell, Girl Scout director, and Marjorie Auge, a Fond du Lac Girl Scout, whom the auxiliary sent to camp last summer.

Miss Sell addressed the group on the objects of the Girl Scout organization. She told of the number of troops being sponsored in the city by various organizations and made a plea for cooperation and help in carrying out the Girl Scout program, the purpose of which is to create good citizens. The Girl Scout guest spoke on what her organization is doing for her.

Plans for a Hygeia campaign in December were discussed at the business session. Twenty-six were seated for dinner.

With Mrs. E. J. Carey of Milwaukee, national Hygeia chairman, as honor guest and speaker, members of the Fond du Lac auxiliary met for a one o'clock luncheon on December 4 at the home of Mrs. C. W. Leonard of Fond du Lac. The committee in charge consisted of Mrs. Leonard, Mrs. L. J. Simon, Mrs. A. M. Hutter, and Mrs. S. A. Theisen.

Twenty-eight members were served luncheon at tables decorated with pink and yellow chrysanthemums. Place cards corresponded with the floral

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decorations, as did a corsage presented to the honor guest.

Speaking in the interest of Hygeia, a campaign for which is being conducted during December and January, Mrs. Carey pointed out why the American Medical Association had chosen the magazine for the auxiliary's project and outlined its policy.

A general discussion and social hour followed Mrs. Carey's address. Mrs. H. E. Twohig, presided at the meeting.

Kenosha

When the Woman's Auxiliary to the Kenosha County Medical Society concluded its December business meeting at the home of Mrs. H. S. Murphy of Kenosha, Mrs. G. C. Schulte, the retiring president, presented the gavel to the new president, Mrs. H. L. Schwartz, who assumed the duties of office.

Following a custom of former years Mrs. Schwartz appointed a committee to consult with the hospital staffs in order to purchase gifts for children confined in the hospitals. At the close of the meeting a Christmas party was held, gifts exchanged, and bridge played.

The tea table arranged by the hostess was beautifully decorated with a mirror in which were reflected reindeer and tips of Jack pine glistening with snow. Assisting Mrs. Murphy were Mesdames W. C. Kleinpell, I. E. Bowing, and W. H. Lipman.

Milwaukee

Twigs of holly and evergreen forming centerpieces on the tables evoked a Christmas spirit at the annual holiday luncheon of the Woman's Auxiliary to the Medical Society of Milwaukee County on Friday, December 8, at the Cudworth Memorial Building. Eighty-five members were present.

The program was splendid and included several delightful selections by Miss Helen Furkert, harpist. An interesting and humorous, as well as educational, talk on cosmetics was given by Dr. P. C. Barton of the Bureau of Investigation of the American Medical Association.

The eighth annual business meeting followed. The minutes of the last annual meeting were read and approved. The president, Mrs. R. E. McDonald, read her report. Reports of other officers and of chairmen of standing committees were read and accepted. The corresponding secretary read a letter from the board of directors of the Premature Infants' Bureau acknowledging the auxiliary's gift of $150.

The report of the nominating committee was read and accepted:

President-Elect—Mrs. R. D. Champney
Vice-President—Mrs. R. D. Bergen
Corresponding Secretary—Mrs. W. H. Studley
Recording Secretary—Mrs. R. C. Pfeil
Treasurer—Mrs. Charles Fidler
Directors (term two years)—Mrs. W. B. Ford, Mrs. V. F. Lang, and Mrs. W. C. Liefert.

As Mrs. McDonald turned over the gavel to the new president, Mrs. C. D. Partridge, a bouquet of roses in behalf of the auxiliary's appreciation of her excellent work, was presented to the retiring president by Mrs. G. H. Friedman. Mrs. Partridge read her message stating the aims and purposes toward which the auxiliary would strive and asked the cooperation of all members.

The next meeting will be a tea in honor of the new officers.

In honor of Mrs. R. E. McDonald, the retiring president of the Milwaukee Auxiliary, the officers, directors, and past-presidents entertained her at a luncheon at the City Club. Mrs. McDonald was presented with a crystal flower bowl filled with white chrysanthemums and yellow snapdragons, and matching crystal candlesticks. Present at the luncheon were Mesdames J. G. Taylor, Rock Sleyster, W. M. Jermain, R. W. Washburn, R. E. Fitzgerald, J. J. McGovern, R. P. Gingrass, G. J. Pugh, E. P. Bickler, H. J. Cannon, R. W. Blumenthal, W. F. Grotjan, S. M. Markson, Joseph Lettenberger, and G. H. Friedman. Regrets were sent by Mesdames E. J. Carey, H. J. Heeb, C. D. Partridge, and J. C. Sargent.

Portage

Mrs. T. L. Harrington of Stevens Point was elected president of the Woman's Auxiliary to the Portage County Medical Society at a meeting held on December 11 at the home of Mrs. Carl von Neupert, also of Stevens Point. Mrs. W. C. Sheehan was chosen president-elect, and Mrs. P. N. Sowka was elected secretary and treasurer. Bridge and Chinese checkers were played after the business meeting. A buffet luncheon was served, with Mrs. A. G. Dunn, the outgoing president, pouring.

Winnebago

A luncheon meeting of the Woman's Auxiliary to the Winnebago County Medical Society at Steim's on November 27 was attended by thirty members. In addition, Mrs. S. R. Beatty, Mrs. James Meli, and Mrs. C. H. Helmes were guests. Mrs. R. H. Bitter, the president, presided during the business session.

Mrs. G. H. Williamson, chairman of Hygeia, reported that the publication will be placed in various beauty shops in Oshkosh, Neenah and Menasha.

After the business meeting Mrs. W. A. Wagner was hostess to the group at her home, where the members finished dressing dolls to be distributed by the county nurse, Miss Katherine Weinman, to needy children at Christmas time.

THE COMMON COLD IS IMPORTANT

"But the common cold, while not threatening life, is, because of its prevalence, a very important disease, accounting for a tremendous loss of working time and a still greater loss of working efficiency."

Jerome R. Head, Illinois Med. Jl. September, 1939

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With Neo-Synephrin Hydrochloride at your command, you can readily abate the nasal congestion which accounts for so much distress during a cold.

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Quickly Effective—Vasoconstrictive action begins within a few minutes after application.

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How Services of Crippled Children Division Are Financed

By FLORENCE L. PHENIX
Madison
Supervisor, Crippled Children Division, State Department of Public Instruction

THE services for which the Crippled Children Division, State Department of Public Instruction, is responsible, are financed through both state and federal funds. These services include care and education as provided through orthopedic schools, the academic instruction provided in hospitals for crippled children, orthopedic examinations through orthopedic fields clinics and transportation to hospitals for orthopedic care.

During the past school year, 928 children were provided service through the eleven orthopedic schools in this State. These children for the most part, were enrolled for the purpose of receiving physical therapy. A few attended for school facilities only because adjustment of local school accommodations could not be arranged.

The cost of attendance at the orthopedic school is great because the children receive, in addition to their regular academic instruction, physical therapy under a physician's prescription, transportation to school and a warm noon lunch. In addition to this, maintenance costs are paid for those children residing outside of the community in which the orthopedic school is located. Because orthopedic school care is expensive it is necessary to limit enrollment to those children who can receive benefit from the therapeutic service provided. There are, of course, a few instances where it would be impossible for a child to attend school at all if he were not allowed to enroll in an orthopedic school. In these cases the cost of orthopedic school attendance would, undoubtedly, be justified even though the cost is considerably more than regular school costs.

For the past fiscal year reimbursement for the cost of orthopedic schools was granted to the amount of $164,824.05. Of this amount, $120,000 was paid from state funds and the remaining $44,824.05 from federal funds.

The cost of academic classes in hospitals for crippled children is reimbursed in full to the city supervising the work and is included in the $164,824.05 paid as costs of orthopedic schools.

Orthopedic field clinics are financed through federal funds granted the Crippled Children Division. The money spent for the field clinics, includes an honorarium of $50 a day and expenses for each orthopedic surgeon invited by the county medical societies to conduct examinations at these clinics. An additional $25 is allowed the orthopedist when invited by the county medical society to address the group the evening before or following the clinic. The cost of necessary x-ray films ordered and read by the examining orthopedists, and taken on the day of the clinic, is paid from Crippled Children Division funds when parents are unable to pay such costs. During the past fiscal year, 1,033 examinations were made at orthopedic field clinics at a cost of $2,355.06. This amount is exclusive of the cost of stenographic service at the clinic and the cost of assistance granted through the field staff of the Crippled Children Division. Of this amount, $1,646.30 was spent for fees and travel expense of the examining orthopedists, $618.80 for x-ray work and the remaining $89.96 for laundry and supplies.

The cost of transportation between a child's home and the hospital where orthopedic care is provided for him, may be paid by the county court with reimbursement from funds granted the Crippled Children Division for that purpose, if the parents are financially unable to pay the cost. Such reimbursement is granted to cover bus or train fare and necessary taxi service. The appropriation for this service is $2,500 for the present fiscal year and is paid entirely from state funds. The value of providing financial assistance for transportation seems greatest for those children living a great distance from orthopedic hospital facilities and in counties in financial stress where local assistance for transportation is difficult to arrange. With the present financial assistance made available to the counties, children return more regularly for recommended examination and treatment, making the end result of the initiated care more satisfactory.

In addition to the cost of these services, the Crippled Children Division pays the cost of a limited field and administrative staff and maintains individual case records for all crippled children reported to this office. During the past fiscal year $206,369.61 was used in paying the costs of services administered through the Crippled Children Division. Of this amount, $130,696.75 was made available and paid from state appropriations and $75,672.86 from federal money granted.

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CAPSULES SOBISMINOL MASS SQUIBB for oral use contain 0.75 Gm. Sobisminol Mass and represent 150 mg. bismuth equivalent. In bottles of 100 and 1000 capsules. Aver. adult dose, 2 capsules. t. i. d.

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Sobisminol Mass and Sobisminol Solution have been subjected to extensive pharmacologic and clinical study. The results of the studies indicate that these preparations are promptly and quite uniformly absorbed, usually well tolerated, and have a wide margin of safety. The bismuth therein is excreted at such rates and in such quantities as to indicate that there is little accumulation of the metal while the quantities retained are adequate for a sustained systemic antisyphilitic effect.

Sobisminol Mass, given orally, has been shown to have an antisyphilitic effect comparable to that produced by Sobisminol Solution and other soluble compounds of bismuth injected intramuscularly. The preparation has been administered orally daily for periods of many months without producing evidence of cumulative toxic effects. It can be used wherever bismuth therapy is indicated in the treatment of syphilis, including its use with one of the arsenicals or in alternate courses with arsenicals according to the preference of the clinician.

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ionization, defining most of its terms quite thoughtfully as it proceeds. The number of new terms and ideas presented could furnish a stiff course of study for the uninitiated that would easily last two or three years. But even the initiated who have had time to forget will find the simplified explanations convenient to have available for quick refreshment of memory. M. S. K.

Primer of Allergy: A Guidebook for Those Who Must Find Their Way Through the Mazes of this Strange and Tantalizing State. By Warren T. Vaughan, M.D., Richmond, Va. One hundred and forty pages, illustrated. Price, cloth, $1.50. St. Louis: The C. V. Mosby Company, 1939.

The *Primer of Allergy* should prove a boon alike to the physician and his patient. It is an outstanding work covering the vast amount of technical and detailed information about the allergic state which has accumulated as clinical and laboratory investigation has progressed. Much of the material, however, is not readily understood by the general reader and is of interest only to the physician and research worker.

Everyone who treats allergic diseases realizes the necessity of imparting to the patient all the information possible regarding the etiology of his affliction and the various procedures—specific and nonspecific—to be followed in arresting or relieving the symptoms. This requires unlimited time and patience.

Dr. Vaughan's Primer presents general information about the allergic state in a most interesting and logical way. The 140 pages are divided into ten chapters each with arresting titles, i.e., The Enemy—Allergens; Defense of the Realm—Methods of Combating Sensitization; Plan of Attack—The Therapeutic Program, etc.

Questions likely to be asked, with their answers, are incorporated at the end of each chapter. Appropriate and fascinating illustrations by John P. Tillery head the chapters and several interesting cartoons by H. T. Webster from the New York Herald Tribune are included in the text. The reviewer recommends that this book be read by all physicians, medical students, hypersensitive individuals and their families—particularly the latter.

Dr. Vaughan also presented to the profession this year his *Practice of Allergy*. W. A. M.

Psychobiology and Psychiatry: A Textbook of Normal and Abnormal Human Behavior. By Wendell Muncie, M.D., associate professor of psychiatry, Johns Hopkins University; assistant psychiatrist, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital. With a foreword by Adolf Meyer, M.D., LL.D., Sc.D., Henry Phipps professor of psychiatry and director of the Department of Psychiatry, Johns Hopkins University, Baltimore, Md. Seven hundred and thirty-nine pages with sixty-nine illustrations. Price, cloth, $8. St. Louis: The C. V. Mosby Company, 1939.

This textbook is intended primarily for medical students and contains, in summary, the material presented in courses in psychobiology and psychiatry at the Johns Hopkins Medical School. The content is divided into four parts. Part I is concerned chiefly with the study of normal behavior by means of an intensive investigation of the student's own personality. The technic of making a personality study is presented in detail and the need of synthesizing the data for the purpose of evaluating the assets, liabilities, and modes of adjustment is presented. An analysis of normal behavior forms the groundwork for the study of psychopathology and psychiatry and leads logically to Part II. This section contains an exposition of all forms of abnormal behavior. The student is first familiarized with systematic methods of obtaining a psychiatric case history and of making a direct examination of a mentally sick patient. This is followed by a description of clinical psychiatric syndromes, using the nomenclature recommended by Adolph Meyer. Many excellent excerpts of clinical records are used to illustrate the various forms of psychopathology and psychiatric syndromes.

The sixty-eight pages of Part III deal with treatment from the standpoint of general principles and specific therapeutic procedures for each of the syndromes enumerated in the text. A novel feature in this book is Part IV which is a historical survey in chronologic order of the development of clinical concepts such as neurasthenia, hypochondriasis, anxiety states, and other conditions. The historical data are arranged in parellel columns containing the views of French, German, English, American, and other psychiatrists and physicians in regard to each of the above clinical concepts at a given period.

Although the author's viewpoint is definitely psychobiological, he discusses briefly other approaches, such as Kraepelinian psychiatry and psychoanalysis, to the study of human behavior. This is an excellent psychiatric text not only for students but also for medical practitioners, in spite of the somewhat involved literary style. J. P.

An Introduction to Medical Mycology. By George M. Lewis, M.D., member of the American Dermatological Association, Inc.; fellow of the American College of Physicians, of the American Medical Association and of the New York Academy of Medicine; member of the Manhattan Dermatological Society; associate and assistant attending dermatologist, New York Post-Graduate Medical School and Hospital, Columbia University; instructor in medicine (dermatology), Cornell University; attending dermatologist to St. Claire's Hospital; etc. In collaboration with Mary E. Hopper, M.S., assistant in mycology, skin and cancer unit, New York Post-Graduate Medical School and Hospital, Columbia University. Three hundred and fifteen pages with seventy-one full-page plates. Price, cloth, $5.50, postpaid. Chicago: The Year Book Publishers, Inc., 1939.

This is an outstanding work and one which might well serve as a model for many of our other medical authors and publishers. The subject matter is pre-

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sented in a clear concise manner and the many photographs are well selected and illustrative of the conditions such as are encountered in everyday practice.

The first portion of the book consists of about 200 pages on the clinical, theoretic and experimental aspects. There is a chapter on the methods of diagnosing fungous diseases, one on the various skin tests that are employed and short chapters on the allergic manifestations of fungi and on immune bodies in the blood stream. The bulk of the section however, is devoted to a consideration of the superficial and the deep mycoses. The manner of presenting this material in an orderly, clear, concise fashion in which emphasis is placed on diagnosis and treatment makes the section a most useful and practical one.

The second portion is made up of about 100 pages on laboratory methods. There are several short chapters on such topics as the direct examination of fungi, their appearance in hair, scales, skin, etc., their characteristics on culture, and the microscopic characteristics of the dermatophytes. The bulk of the section, however, is given over to descriptions of those fungi that are pathogenic.

The authors have succeeded in presenting this material in an understandable, not-too-technical style that will be welcomed by the busy practitioner. R. McI.

The Art of Anaesthesia. By P. J. Flagg, M.D., visiting anesthetist to Manhattan Eye and Ear Hospital; consulting anesthetist to St. Vincent's Hospital, New York City; consulting anesthetist to the Woman's Hospital, Sea View Hospital, Jamaica Hospital, Mt. Vernon Hospital, Flushing Hospital, Mary Immaculate Hospital, and others, New York; director of pneumatology, World's Fair, New York City, and chairman of Committee of Asphyxia of the American Medical Association. Ed. 6, revised. Four hundred and ninety-one pages; 161 illustrations. Philadelphia: J. B. Lippincott Company, 1939. Price, cloth, $6.

Dr. Flagg's "The Art of Anesthesia" is already well known. Throughout the sixth edition, the illustrations have been modernized. These have been well done. Many of those of apparatus and materials rather unwisely display the manufacturer's name prominently.

The all too brief chapter (three pages) on records has been rewritten. The importance of preoperative and postoperative information concerning patients is not sufficiently emphasized. The chapter on basal anesthetics has also been rewritten. A few of the more commonly used drugs in this category are conservatively discussed. In this chapter, morphine and dilaudid are erroneously referred to as hypnotics. A brief and rather confused reference is made to agranulocytosis. Seven new chapters have been added. Carbon dioxide absorption from anesthetic atmospheres and cyclopropane are dealt with briefly and conservatively. Misstatements are present but are relatively few in number.

There is a chapter on new anesthetic agents and technics. Herein the use of helium is described. Divinyl ether or vinethene is presented. The author mentions his technic for anesthesia in brain surgery and thoracic surgery. He offers a case report of a typical example of endotracheal ether anesthesia used for thoracic surgery. The ordinary "tin can" technic for ether administration in intrapleural surgery may be typical for the author but is certainly not generally accepted as such. Diabetes and epilepsy are also discussed briefly in this chapter. A presentation is made of Hyman's work in regard to resuscitation of the heart. The chapter ends with an interesting but somewhat irrelevant illustrated description of the plastic material, Lucite.

Dangers encountered in the administration of anesthetics for oral surgical procedures are handled in the chapter, "Dental Anesthesia and Analgesia."

We owe much to the author for his contributions in endotracheal anesthesia. In this new edition of his book, he has added six pages to the subject of laryngeal intubation.

In the chapter on causes of death in anesthesia, there is good material but it is rather poorly presented.

The last chapter contains a plea for the coordination of the activities of gas therapy, anesthesia, and resuscitation in medical educational centers and hospitals, under the direction of a department of pneumatology.

There is one important criticism of the book; namely, there are practically no references (other than the author's personal bibliography). When the first edition was presented, there was very little literature on anesthesia available; therefore, the author had to draw from his personal experiences. With awakened interest in anesthesia and allied subjects, this situation is not true today. The reader should bear in mind that many of the author's views are open to controversy and should therefore be regarded as opinions and not in all cases as absolute solutions to the problem at hand.

In conclusion, the reviewer recognizes the "art" in anesthesiology or pneumatology, as the author wishes to call it, but believes there is also science. Dr. Flagg emphasizes art at the expense of science. More of a balance would seem to be advisable. H. R. H.

A Topographic Atlas for X-ray Therapy. By Ira I. Kaplan, M.D., director, Radiation Therapy Department, Bellevue Hospital; director division of cancer, department of hospitals, City of New York; clinical professor of surgery, New York University Medical College; associate visiting radiologist, Lenox Hill Hospital, New York City; editor of "Therapeutics" in the *Year Book of Radiology*. In collaboration with Sidney Rubenfeld, M.D., associate visiting radiation therapist, Bellevue Hospital; instructor in surgery, New York University Medical College, assistant adjunct radiation therapist, Hospital for Joint Diseases, New York City. One hundred and twenty pages with fifty-five full-page plates. Price, cloth, $4. Chicago: The Year Book Publishers, 1939.

In roentgen therapy it is important to localize the fields of exposure accurately and this requires a thorough knowledge of topographic anatomy. It is particularly necessary for the radiologist to be familiar with the location of the various organs in relation to the body surface. The authors felt that there exists a need for a special atlas showing the projections of the various organs on the body surface and also the position of the ports of entry used in roentgen therapy. As stated in the introduction it "is a practical utilitarian atlas, by no means intended as a comprehensive work on medicine or surgery." E. A. P.

Synopsis of Pediatrics. By John Zahorsky, A.B., M.D., F.A.C.P., professor of pediatrics and director of the Department of Pediatrics, St. Louis University School of Medicine, and pediatrician-in-chief to the St. Mary's Group of Hospitals; fellow of the American Academy of Pediatrics. Assisted by T. S. Zahorsky, B.S., M.D., instructor in pediatrics, St. Louis University School of Medicine and assistant pediatrician to the St. Mary's Group of Hospitals. Ed. 3. Four hundred and thirty pages, 153 illustrations—including nine color plates. Price, cloth $4. St. Louis: The C. V. Mosby Company, 1939.

This small book of 430 pages represents an excellent condensation of the modern knowledge of pediatrics which is designed particularly for the teaching of the clinical aspects of disease in infancy and childhood to medical students. The authors have revised many chapters and have added recent contributions from the pediatric literature. New sections have been added to the chapters on growth and development, prematurity, the newborn, nutrition and therapeutics. The book contains many fine illustrations and colored plates.

The discussion of diseases such as tuberculosis, pneumonia and the diseases of nutrition are surprisingly complete from a clinical standpoint. The fundamental aspects, such as the pathological anatomy and physiology, and laboratory studies, are necessarily very briefly considered since the purpose of the book is to stress the important clinical findings in diseases as they are encountered in the home and office practice of the general practitioner. K. B. McD.

The Ophthalmoscope and Studies of the Fundus Oculi in Important Pathological Conditions. Chicago: The American Optical Company, 1939.

This is a booklet of thirty-two pages, the author of which is not stated. The ophthalmoscope is described in some detail, both its mechanism and indications for use. A diagram is presented showing the various branches of medicine in which the ophthalmoscope plays an important role. A normal fundus is described briefly. Five colored plates of pathological conditions of the fundus are shown.

The booklet is exceedingly brief and covers only an exceedingly small phase of pathology of the fundus. P. A. D.

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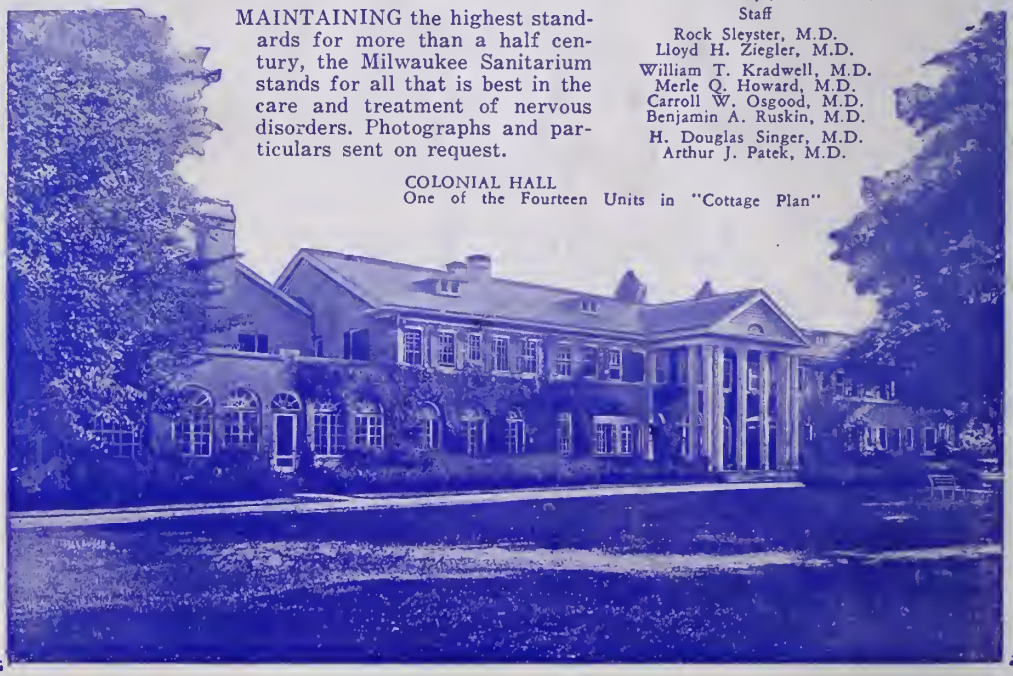

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IN THIS ISSUE

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By T. J. Dry, M. B.

EARLY POSTOPERATIVE FEEDING
By P. H. Halperin, M. D.

BROMISM
By O. C. Clark, M. D.

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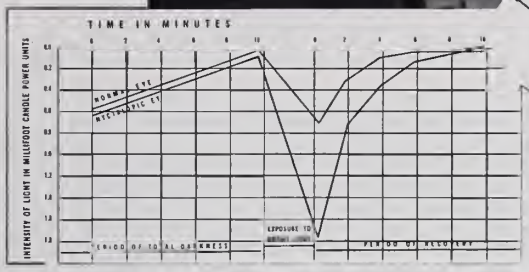
STUDIES IN THE AVITAMINOSES

This page is the second of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A two-page insert on the same subject appears in the February 17 issue of The Journal of the American Medical Association.

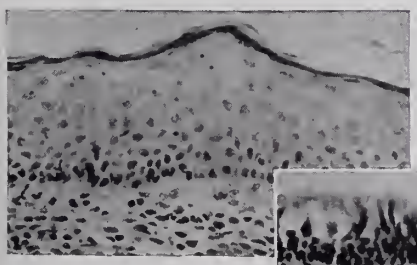
Manifestations of Vitamin A Deficiency

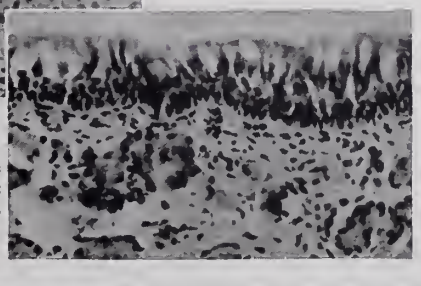
One of the early manifestations of vitamin A deficiency is nyctalopia, a loss of visual acuity in dim light. While several pathologic states (retinitis pigmentosa, toxic amblyopia, detachment of the retina) also produce night blindness, vitamin A deficiency is probably the most frequent cause. After exposure to the blinding glare of a bright light the normal eye adapts itself relatively quickly to lowered illumination. In nyctalopia due to vitamin A deficiency, the time required for recovery of visual acuity is longer.

In otherwise normal eyes, measurement of capacity for dark adaptation by means of the biophotometer has been suggested as a method of discovering vitamin A deficiency.



Lower line shows the longer time required for the recovery to pre-exposure level by the nyctalopic.





Above, stratified, keratinizing epithelium of the turbinate mucous membrane of a vitamin A deficient monkey; at right, normal mucosa.

Pathologic epithelial changes produced by vitamin A deficiency are illustrated by the photomicrographs of turbinate mucous membrane taken from normal and vitamin A deficient monkeys. The progressive pathologic process consists of atrophy of the epithelium, reparative proliferation of the basal cells and finally, as depicted in the upper photograph, replacement of the normal by a stratified, keratinizing epithelium.

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METHODS FOR QUANTITATIVE ESTIMATION OF THE VITAMINS

V. The Determination of Riboflavin

● In 1929, the so-called "water-soluble vitamin B" was considered to be composed of two factors, heat-labile vitamin B and heat-stable vitamin G (American nomenclature). General recognition of the existence of vitamin G stimulated research on methods for its quantitative estimation. As a result, a number of bioassay methods for vitamin G were evolved (1, 2) and widely used to determine the vitamin G values of foods.

By 1937, however, it was evident that the heat stable fraction of the vitamin B complex was not a single entity, but rather a mixture of essential factors, among them the yellow-green fluorescent pigment, riboflavin (3). Hence, another chemical compound has recently attained significance in human nutrition (2, 4). The establishment of specific methods for the determination of riboflavin in foods immediately became of interest to workers in the field of nutrition.

As to methods for estimation of riboflavin, it is commonly accepted that the Bourquin-Sherman bioassay method (5)—originally devised for vitamin G—measures riboflavin rather than any other factor (2). This method provided for depletion of the body stores of young rats by confinement to a specified "vitamin G-free" diet and determination of the growth response of the animals to graded supplementary doses of the material under assay. One Bourquin-Sherman vitamin G unit is now considered equivalent to 2-5 micrograms (1/1000 milligram) of riboflavin, the probable average value being about 3 micrograms.

Attempts have also been made to devise a physico-chemical method for estimation of this factor. The yellow-green fluorescence of riboflavin solutions—reaching its maximum between pH 6.0 and pH 7.0—is one of the distinctive properties of this compound (6). The measurement of the intensity of this fluorescence appears to be a promising method for estimating the riboflavin content of a suitably prepared solution, within certain ranges of riboflavin concentrations. However, many difficulties such as the complete extraction of riboflavin from foods and the removal of interfering materials from the extract must be overcome before fluorometric methods can be applied to the determination of riboflavin in all foods. However, recent reports demonstrate that fluorometric methods are adaptable to the estimation of riboflavin in certain specific foods and that a reasonable correlation may be expected between values determined by fluorometric and bioassay methods (7).

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(2) 1939. The Vitamins: A Symposium, page 289. American Medical Assn., Chicago.
(3) 1939. The Vitamins: A Symposium, page 127. American Medical Assn., Chicago.
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(5) 1931. J. Am. Chem. Soc. 53, 3501.
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(7) 1939. Ind. Eng. Chem. Anal. Ed. 11, 495.
1937. J. Am. Chem. Soc. 59, 1153.
(8) 1938. Nutrition Abstracts and Reviews 8, 281.
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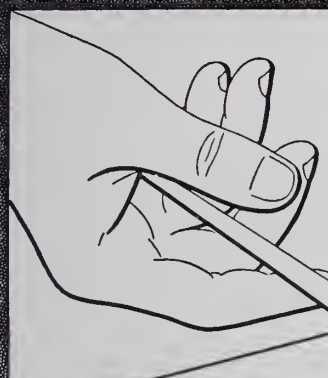

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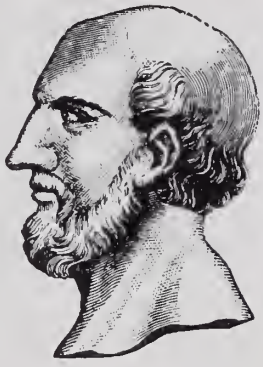

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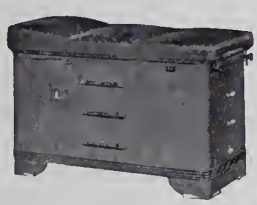

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Pulmonary Hypertension and Failure of the Right Side of the Heart*

By THOMAS J. DRY, M. B.
Rochester, Minn.

THE physiologic purpose of the right side of the heart is to propel venous blood through the pulmonary circuit. The physiologic purpose of the left side of the heart is to distribute the same blood after oxygenation to the systemic circulation.

These two units are inseparable and it is important to visualize clearly their functional continuity and the anatomic relationship that exists between the systemic and pulmonary circulations.

An important consideration in discussing problems associated with arterial disease is the concept of a vascular reserve. The pulmonary arterial tree, like other parts of the vascular system, is endowed with a vascular area and a capillary bed greater than ordinary functional demands can exceed.[1,2,3] Otherwise stated, only a certain proportion of the capillaries carry blood at any one time. It follows, therefore, that unless this reserve is encroached on to a considerable extent by the obliteration of many capillaries or the more proximal radicles from which they arise, evidence of disturbed cardiorespiratory function may remain entirely in abeyance.

Increased pressure within the pulmonary circuit may arise under a variety of circumstances. In so far as no practical method exists whereby the pressure within the pulmonary circuit can be determined, the recognition of pulmonary hypertension depends on a knowledge of the various mechanisms capable of producing it and on the recognition of the secondary phenomena resulting from its presence.

The various conditions resulting in increased pressure within the pulmonary circuit may be classified conveniently into these groups: (1) obstruction to the pulmonary circuit beyond the pulmonary system, (2) obstruction to the pulmonary circuit within the pulmonary system, (3) abnormal shunts of blood from the arterial side into the pulmonary circulation, as is exemplified by certain types of congenital heart disease, and (4) kyphoscoliosis.

Obstruction beyond the pulmonary circuit.—Mitral stenosis produces pulmonary hypertension by mechanically impeding the efferent blood stream from the lungs, since there are no valves at the mouths of the pulmonary veins. In some cases the arterioles undergo obliterative changes[4,5] which further increase the work of the right side of the heart.

A failing left ventricle for any cause similarly overloads the pulmonary system. The clinical findings incidental to pulmonary hypertension under these circumstances are, however, overshadowed by the primary disease, but on occasions the effects on the right side of the heart may proceed to preponderant hypertrophy of the right ventricle, a condition which may even be reflected electrocardiographically by right axis deviation.[6]

Obstruction within the pulmonary circuit.—The lesser circulation may be obstructed at different levels. It is apparent that lesions obliterating the larger radicles of the pulmonary arteriolar tree will curtail pulmonary reserve more rapidly than lesions affecting the smaller and more peripherally placed ramifications. By the same token a process affecting the pulmonary circulation at the capillary level, such as emphysema, must of

* From the Division of Medicine, The Mayo Clinic. Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

necessity be widespread and extensive in order to handicap the flow of blood through the lungs materially.

The main pulmonary vessels.—These may be occluded by an embolus resulting in the syndrome of acute cor pulmonale, representing, if nonfatal, an acute, though transitory, pulmonary hypertension characterized clinically by accentuation of the second pulmonic sound and electrocardiographically by a set of findings indicative of right ventricular strain.[7,8,9]

A thrombotic process obliterating the larger pulmonary radicles has been reported in a number of instances.[10,11,12,13] If this is sufficiently widespread to exhaust the pulmonary reserve the usual events leading up to failure of the right side of the heart follow. The underlying basis for such thrombotic processes is seldom apparent.

Small and medium-sized pulmonary arterial branches.—These may be occluded in the course of sickle cell anemia,[14,15] of so-called carcinomatous lymphangitis[16,17] or of schistosomiasis.[18] In sickle cell anemia microscopic studies reveal widespread thrombosis and endarteritis involving the small and medium-sized pulmonary arteries. In carcinomatous lymphangitis the occlusive changes result apparently from perivascular lymphatic infiltration with carcinomatous cells and proliferative connective tissue changes incidental to this. The primary malignant process is usually in the stomach. In schistosomiasis it will be recalled that infection occurs through the skin and that the parasites are carried by the blood stream to the lungs, pass through them to the systemic circulation and end mainly in the portal system. In certain cases residual infestation in the lungs results in granulomatous lesions within or related to the blood vessels. Many small arteries may become secondarily obliterated eventuating in pulmonary hypertension and failure of the right side of the heart.

Pulmonary arterioles. — The pulmonary arterioles may undergo obliterative changes in association with many pulmonary diseases as well as with mitral stenosis. The coexistent pulmonary disease has frequently been incriminated as the cause of the failure of the right side of the heart which eventually occurs without any regard to the obliterating arterial disease that may very well be the essential factor in the genesis of pulmonary hypertension. In certain cases, arteriolar sclerosis exists when no etiologic factor is demonstrable in the heart or pulmonary system. The term primary pulmonary arteriolar sclerosis aptly describes this syndrome.

The capillary system.—When obstruction occurs to radicles of the pulmonary artery at levels proximal to the capillary bed, the corresponding sets of capillaries are put out of commission automatically. Capillary obliteration occurs independently, however, in emphysema (through destruction of the interalveolar walls) and in widespread pulmonary fibrosis due to tuberculosis or pneumoconiosis (by destroying pulmonary tissue). In many cases of so-called emphysema heart with failure of the right side of the heart capillary obliteration is only one factor. Until recently the changes in the arteriolar bed again have been either overlooked or ignored.

In a study of a group of patients suffering from essential emphysema, Parker[19] noted that the greater the degree of emphysema, the greater was also the degree of right ventricular hypertrophy and the greater was the incidence of congestive heart failure.

A superficial analysis using these data alone would lead to the erroneous conclusion that the emphysema per se is the essential factor in bringing about these changes on the right side of the heart. However, when the degree of obliterative arteriolar changes was coincidentally studied is was found that, with one notable exception, the degree of arteriolar sclerosis was also greatest in these cases showing the more advanced degrees of emphysema and those associated with right ventricular failure. Again emphysema may occur without hypertrophy of the right ventricle. It must also be recalled that emphysema most frequently occurs among individuals who have reached the decades when diseases causing left ventricular failure are very common.

Abnormal shunts of blood from the arterial side into the pulmonary circulation.— Any anatomic arrangement which permits of a shunt of blood from the arterial side into the pulmonary circulation may create increased pressure in the pulmonary circuit, depending on the volume of blood shunted.

Congenital arteriovenous shunts. — Thus in patency of the ductus arteriosus an extra quota of blood reaches the pulmonary circulation with each cardiac cycle, inasmuch as the pressure in the aorta is considerably higher than in the pulmonary artery. The reflux of blood from the arterial to the venous side in most cases of uncomplicated septal defects is insufficient to be of any consequence, unless an associated factor coexists which increases the arteriovenous shunt. A classic example of this type is a combination of a patulous foramen ovale and mitral stenosis (so-called Lutembacher's disease). In such cases the shunt is sufficient to cause extreme degrees of pulmonary hypertension with dilatation of the pulmonary artery to aneurysmal proportions.

Acquired arteriovenous shunt. — In rare instances a condition analogous to patency of the ductus arteriosus is created by the gradual rupture of an aortic aneurysm into the pulmonary artery. Such an event may be associated with the roentgenologic and electrocardiographic evidence of pulmonary hypertension and with a bruit simulating that caused by a patent ductus arteriosus.[20]

Kyphoscoliosis. — Kyphoscoliosis presents another interesting problem. The observation that the majority of hunchbacks ultimately succumb to heart failure often has been made. In 154 cases studied by Bachmann,[21] eighty-seven gave evidence of hypertrophy of the right ventricle, twenty-seven of the left ventricle and forty of both ventricles. Here, we are probably dealing with several factors rather than with any single mechanism. Thus, large portions of lung often are atelectatic and are associated with other regions of compensatory emphysema; chronic bronchitis is frequent and the mechanical effect of kinking of the great vessels unquestionably plays a part in producing a picture which tends to terminate in failure of the right side of the heart.

Results and Effects of Pulmonary Hypertension

Any mechanism which leads to increased pressure in the pulmonary circuit, irrespective of its mode of production, increases the work of the right ventricle and, if sustained, as it usually is, will lead to hypertrophy of that chamber. As secondary effects on the pulmonary vessels themselves, there follow arteriosclerotic changes in the main pulmonary arteries and added obstructive effects in the arterioles. Over a period of time, when the reserves are exhausted, failure of the right side of the heart may ensue with resultant dilatation, later tricuspid insufficiency with congestion of the venous system and edema. When pulmonary hypertension is the result of obstruction within the pulmonary circuit, the interference with ventilation and the resulting anoxemia eventually exert deleterious effects on the nutritional status of the left side of the heart, and so set up a vicious cycle. As Waring and Black[22] pointed out, the collateral circulation which may be afforded by the bronchial arteries cannot in any way compensate for the respiratory difficulties inasmuch as these vessels carry oxygenated blood.

The Clinical Picture of Chronic Cor Pulmonale

In short, the clinical picture of chronic cor pulmonale is that of pulmonary hypertension plus the features contributed by the factor responsible for the pulmonary hypertension. In cases of so-called primary pulmonary arteriolar sclerosis, the distinct syndrome of pulmonary hypertension occurs without the presence of complicating factors which would otherwise obscure or distort the clinical picture. There is usually a history of gradually increasing dyspnea as the obliterative process progresses. The resulting interference with ventilation gives rise to cyanosis, which also increases as the disease advances. The striking symptom, then, is dyspnea, which is prominent even in the absence of congestive heart failure and is out of all proportion to other evidence of congestive heart failure, when the right side of the heart does fail. In short, it is the dyspnea of interference with ventilation and this in itself immediately should suggest its

pulmonary origin. It is a characteristic of all pulmonary diseases in which the function of oxygenation is limited.

By the time these patients present themselves for examination, the secondary manifestations of pulmonary hypertension usually can be elicited. The individual often looks older than his chronologic age would imply, and this is accentuated by the cyanosis which is present. The striking auscultatory finding is an accentuated second pulmonic sound. The clinical evidence of a hypertrophic right ventricle is afforded by a systolic pulsation to the left of the sternum best elicited by firm palpation in this region. This is accounted for by the fact that, as the right ventricle becomes hypertrophic, it comes to form, more and more, the anterior surface of the heart and approximates the anterior wall of the thorax more closely. On auscultation, the lungs are likely to be clear even in the presence of congestive failure, because the obstruction is proximal to the alveolar system. It is only when the left side of the heart fails secondary to the effects of anoxemia that congestion of the bases of the lungs comes into the clinical picture.

Confirmatory evidence is afforded by laboratory procedures. Roentgenologic examination reveals a prominent pulmonary conus, an enlarged right ventricle and auricle and usually clear pulmonary fields. Pulsation of the vessels in the pulmonary hilus sometimes can be elicited. An important distinguishing feature is the absence of enlargement of the left auricle which distinguishes cor pulmonale from obstructions beyond the pulmonary circuit, as in cases of mitral stenosis. The characteristic electrocardiographic pattern indicative of predominant right ventricular strain affords corroborative evidence. This consists of right axis deviation which is usually definite unless a mechanism causing predominant left ventricular strain exists. If changes in the T wave occur, they will consist of inversion in the second and third leads and a positive T wave in the (Wolferth) chest lead. There may be secondary polycythemia, the result of anoxemia, but this is often absent.

Angiocardiography after the intravenous injection of diodrast has been employed by Robb and Sternberg[23] to illustrate the changes which occur in the different cardiac chambers, especially the enlargement of the right ventricle and pulmonary artery in a case of pulmonary heart disease.

With failure of the right side of the heart, venous congestion, hepatic enlargement, peripheral edema, ascites and increasing cyanosis are added to the picture and it is characteristic of this disease that, when congestive failure supervenes, the subsequent course is invariably rapidly downhill, a type of congestive failure unusually refractory to therapy.

This description holds essentially for pulmonary hypertension owing to any cause, the provoking disease either in the pulmonary system or in the cardiovascular apparatus, adding its quota to the symptoms and findings described. Pulmonary hypertension secondary to diseases of the left side of the heart and to the congenital lesions enumerated needs no special comment because the corresponding clinical picture in each case bears hallmarks sufficiently well recognized to establish a diagnosis.

With special reference to the pulmonary circuit, one may lay down three principles which afford indirect evidence of the nature of the obstructing lesion.

1. The more proximal the obstruction, that is, the larger the vessels that are occluded, the more profound are the effects.

2. The more rapidly progressive the primary disease, the more rapidly will the picture of failure of the right side of the heart supervene. Thus, in cases of carcinomatous lymphangitis, the course of failure of the right side of the heart is so much more rapid than in other cases of chronic cor pulmonale that the term subacute cor pulmonale has aptly been applied to it.[17]

3. Multiple factors which individually may place an inconsequential burden on the right ventricle, when acting together can become a serious threat to the integrity of the right side of the heart. Frequently, mitral stenosis of minimal degree that has been tolerated perfectly well terminates in congestive heart failure because a disturbance of ventilation such as that caused by emphysema, which in

itself would not be incapacitating, is superimposed on it. The term Ayerza's disease purposely has been omitted from the discussion because this name has been linked with so many varied pathologic and clinical entities that it contributes neither etiologic nor differential diagnostic information.

Summary and Conclusions

Pulmonary hypertension is a secondary manifestation of a wide variety of conditions which exert their effects either by obstruction of the lesser circulation in or beyond the pulmonary circuit, or by shunts of arterial blood into the pulmonary circulation as exemplified by certain types of congenital cardiac anomalies.

The pulmonary circulation is endowed with a rich vascular reserve. Lesions obliterating the larger radicles of the pulmonary arterial tree curtail this reserve and produce pulmonary hypertension more readily than lesions affecting its more peripheral elements. By the same token, exhaustion of vascular reserve to the extent of causing pulmonary hypertension requires a widespread obliterative process, if the obstruction is at the capillary level as in emphysema. The increased incidence of both emphysema and degenerative cardiovascular disease after middle life must be kept in mind as must also be the frequency of obliterative arteriolar changes in chronic pulmonary disease.

Regardless of the mechanism responsible for its production, pulmonary hypertension is recognized by the secondary effects on the cardiorespiratory system eventuating in right ventricular hypertrophy, characterized by accentuation of the second pulmonic sound, roentgenologic prominence of the pulmonary artery and conus and the electrocardiographic pattern of right ventricular strain. Absence of enlargement of the left auricle places the obstruction within the pulmonary circuit. Dyspnea is the prominent symptom and is usually progressive. When the obstruction is situated within the pulmonary circuit, dyspnea is caused by interference with ventilation and is usually prominent even in the absence of congestive features and out of all proportion to other evidence of congestive heart failure, when the right side of the heart does fail. Under these circumstances, too, the pulmonary fields are likely to be unusually clear.

The final syndrome depends on the symptoms and signs that are contributed to this picture by the disease provoking the pulmonary hypertension. The differential diagnosis depends on a knowledge of the possible pathologic conditions capable of producing obliterative pulmonary vascular disease, on a knowledge of the clinical behavior of these conditions, and on a deliberate attempt to elicit evidence of pulmonary hypertension when diseases are encountered which are known to be capable of producing pulmonary hypertension.

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Early Postoperative Feeding

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THE query has been made by Alvarez,[1] "Why do surgeons, as a rule, hesitate to feed their patients early after operations?" This particular question has been a moot point for many years. The gist of this paper will be to show that early postoperative feeding is not only practicable but efficacious in combating the usual postoperative distention and ileus.

Synopsis of Earlier Effort

In reviewing briefly the applied physiology of the intestinal tract, the following observations by Alvarez[1] are of particular note. The pars pylorica of the stomach possesses a rhythmic activity which serves as a pacemaker for the tonus waves in the duodenum. One of those waves serves as the point of departure for a rush wave down the bowel. Such a wave often follows a swallowing movement and is probably a continuation of the ripple that started in the mouth and ran down through the esophagus and stomach. It is for this reason that, whenever active peristalsis is desired, it is logical to make the patient swallow repeatedly, either by the giving of food or prescribing chewing gum.

It seems probable that some of the paresis of the bowel following operations may be attributable to enforced fasting, with the cessation of those swallowing movements which normally serve to start waves moving along the bowel. Alvarez states that in such a case he, as a physiologist, would be inclined to give the patient food as early as he dared.

It is commonly believed that feeding postoperatively is in itself a cause of abdominal distention. Fermentation in the intestinal tract supposedly causes gas formation in the intestinal lumen. The proponents of this theory withhold foods for this reason. It is true that gases play an important role in gastrointestinal distention, but the source of such gas is found elsewhere.

In an attempt to find the sources of gases present in the intestinal tract, Fine and Levenson[2] performed laparotomies on a control series of dogs which had been fed nothing but water for thirty-six hours. After slight manipulation of the intestines the laparotomy wound was closed. Forty-eight hours postoperatively, the dogs were electrocuted and the contents of the small bowel evacuated. The average amount of gas obtained from each dog was approximately 2.5 cc. In another series, in addition to the intestinal manipulation, the ileocecal valve was obstructed with a ligature. Distention followed in two of a series of six animals. When the above procedure was carried out and water withdrawn, practically the same results followed. From this they concluded that moderate or severe trauma apparently played no active part in the production of distention.

Gangrene of the entire small intestine was produced in another group by ligating the superior mesenteric vessels. No distention followed. In another series of operations the esophagus was obstructed with a ligature. Following this laparotomies were performed on the dogs and their intestines inspected. Practically no gas was present. From these findings Fine and Levenson concluded that the greatest source of gas in the intestines was oral in origin, and that it was the result of aerophagia. This is in accord with McIver's thesis.[3] He has found aerophagia to be a potent factor in the production of distention.

With the aforementioned data at hand, Fine and Levenson[2] proceeded to carry out experiments with foods. They utilized closed intestinal loops which extended from the cardia to the ileocecal valve. It was found that glucose in 5 per cent solution in the intestine would not embarass it unless the amount exceeded three quarts. When 50 per cent solution was used tremendous distention took place. The higher the concentration of the glucose solution, the greater was the degree of distention.

Gaseous distention may be caused by a variety of carbohydrate solutions. Orange juice by mouth, after an operation, is a notorious offender. Of all foods, milk produces the greatest amount of gas; custard has a similar effect. Other carbohydrate foods in the form of toast, gruel, macaroni, potatoes, and noodles show a quite benign behavior with reference to gas formation.

Fats slow up peristalsis slightly and play an inhibiting part in the digestion of carbohydrates. Ravdin et al.[1] have noted that fats delay the emptying time of the stomach.

Magnesium sulfate in 25 per cent solution by mouth was found by Fine and Levenson[2] to produce little gas, but large amounts of fluid. These authors believe that stretching of the gut wall by fluids is not adequate to cause an accumulation of gas.

According to Fine and Levenson,[2] Schoen, McIver and Refield have shown methane, hydrogen and nitrogen to be the important gases in producing distention. These nonabsorbable gases compose from 69 to 90 per cent of the gaseous fraction of such foods as orange juice, whole egg, milk and custards. These are the gases that are removed by the expulsive

forces of the intestines. Nitrogen makes up between 27 to 70 per cent of the nonabsorbable fraction. Its sources are from swallowed air or from the blood by diffusion. The actual volume of nitrogen entering the intestinal wall will depend not only on its partial pressure in the blood but also on the gas capacity of the intestinal lumen established by other gases generated within the intentines. Hence, the greater the gaseous distention of the gut, the more nitrogen will enter, until equilibrium with its partial pressure in the blood is reached. Nitrogen must, therefore, be considered as one of the chief components of the distending gases.

Carbon dioxide plays an insignificant part. A small amount of it is always found in the gas content of the bowel; yet it is readily absorbed. In distention, however, the rate of absorption of carbon dioxide is impeded.

Fine and Levenson[2] quote Kato as reporting that extreme degrees of venous obstruction are required to decrease the rate of gas absorption in the small bowel.

McIver, Benedict and Cline[3] believe that postoperative ballooning of the intestine is brought about by positive pressure of gas within the lumen. They stress as a very important source of this gas, the diffusion of blood gases into the intestinal lumen. Carbon dioxide, oxygen and hydrogen sulfide can be absorbed into the blood in considerable quantities. Very little atmospheric air is absorbed because of its similar composition to the blood gases. It, therefore, plays an important part in distention.

Analysis by McIver et al.[3] of the postoperative gases from patients showed the percentage of carbon dioxide to be very close to that in the venous blood. They wrote—"The percentages of nitrogen are uniformly high, and since free nitrogen is liberated in the intestine only in small quantities if at all (Krogh), it must be derived from air: either directly, from swallowed air, or indirectly, by diffusion from the blood stream, which is saturated with nitrogen at four-fifths of an atmosphere of pressure."

Kantor and Marks[6] state that the greatest part of gas produced by digestion is carbon dioxide, coming from the mixture of acid gastric contents and alkaline pancreatic juices. An analysis of flatus by Fries, set forth in their report, shows it is made up of 29.4 per cent nitrogen. Since nitrogen is derived from swallowed air, an appreciable volume of the flatus must be derived from this source.

Kantor and Marks go on to say that such foods as white bread, fine cereals, dextrin and sugar produce little flatulence. It is the cellulose and rich vegetables which cause trouble. In the cecocolon there is specific bacterial action taking place to decompose the cellulose resulting in carbon dioxide, hydrogen, methane and fatty acids. They state—

> "The amount of gas evolved is probably considerable, for Schwartz found that if 100 grams of cellulose were completely decomposed at 38° C., they would yield:
>
> "CO_2 ---------- 19.5 liters
> "CH_4 ---------- 7.5 liters
> "H_2 ---------- 4.0 liters"

It is to be admitted that other factors play a role in the production of distention, i.e., type of operation, magnitude of operation and amount of tissue trauma. Operations on the biliary tree and high intestinal sections always produce some pylorospasm and distention.

Mahoney[8] states that whenever starvation supervenes, bacteria normally present in the large bowel increase enormously and produce large amounts of flatus. If lack of food, to which the upper bowel is not accustomed, continues for more than a very few hours, these species of bacteria normally resident in the colon and cecum ascend into the ileum and proliferate there, thus giving rise to considerable amounts of gas. The secretion of gastric juices, bile and digestive ferments keeps these bacteria down to a minimum. Food, of course, stimulates the secretion of these products in addition to activating peristalsis.

The Author's Study

I employed early postoperative feeding in sixty-five patients, chosen at random from the surgical wards of the Jewish Hospital, Philadelphia. None were chosen who had undergone gastric operations or operations on the biliary tree.

The types of diets given are listed below:

1. *Carbohydrate diet.* — Cooked cereals, jello, custards, hard candy, toast, synthetic fruit juices.
2. *Protein diet.*—Gelatin, beef stock, soups, soft-boiled eggs, lean meats.
3. *Carbohydrate and protein diet.* — A combination of the carbohydrate diet and the protein diet described above.
4. *Control diet.* — Liquids for forty-eight hours, then a soft diet.

Observations on the sixty-five patients were facilitated by the use of the following diet sheet:

Name_____ Age_____ Sex_____
Operation _____
Type of anesthetic_____ Length of anesthesia_____
Type of diet _____
Gas pains before diet_____ Gas pains after diet_____
Distention_____ How much?_____
Gas passed per rectum _____
When first noted after diet_____
When first noted without diet _____
Morphine administered_____ How often?_____
Spontaneous bowel movement with diet _____
without diet _____
Enema with diet_____ without diet_____
Remarks: _____

The patients were seen as soon as possible after their recovery from anesthesia. At this time the diet was prescribed. The nurse in charge of the floor then made careful observations pertinent to the purpose of this study and recorded them on the diet sheet. In addition, the patients were seen by me three to four times during each twenty-four hour period, when they were examined and questioned about their reactions to the diet.

The postoperative protein diet, it can readily be seen, was not a very palatable one. Approximately 25 per cent of the twenty-three patients taking this diet vomited almost immediately after its ingestion. This, I am sure,

was psychic and due to the fact that it was not palatable. Most of the patients had to be forced to eat and many complained bitterly that they had no desire to eat such food. The average time postoperatively at which this diet was given was 10.8 hours. About half of these patients had mild gas pains before eating, and approximately 44 per cent experienced some form of gas pain after eating. This was usually quite transitory, lasting but a few minutes. One patient in this group became moderately distended. Flatus per rectum was noted twenty-seven hours postoperatively. Five of the group had spontaneous bowel movements, eliminating the necessity for a routine enema.

Eleven persons were placed on the carbohydrate diet. The diet was given about nine hours postoperatively. Two had mild gas pains before eating, and four had slight gas pains after eating. No patient in this group became distended. In these patients routine enemas were employed forty-eight hours postoperatively. One of the group vomited after eating.

Twenty patients were given the combined protein and carbohydrate diet. The average time postoperatively at which this diet was given was twelve hours. Nine of this group experienced gas pains prior to eating. Four had gas pains after taking the diet. None of the patients had distention. Gas per rectum was noted on an average of twenty-five hours postoperatively. Two had spontaneous bowel movements. Enemas were administered at approximately forty-eight hours postoperatively.

Eleven patients were treated in the routine manner of giving nothing but fluids (tap water-unsweetened tea) for forty-eight hours. In every instance these patients experienced, at some time or other during this forty-eight hour interval, gas pains varying in intensity. At the end of forty-eight hours they were placed on the usual soft diet. The average patient in this group began to pass gas per rectum at the end of forty-five hours. There were no cases of distention.

Conclusions

A summary of the observations made as a result of these studies leads to the following conclusions. Early postoperative feeding is practicable, and obviously efficacious in combating postoperative gas pains and distention. Gas pains occur less often and peristalsis is reestablished earlier as evidenced by the fact that patients begin to pass flatus sooner. The type of diet administered is important. It should be of semi-solid consistency and should not contain foods that might produce reflex nausea. Furthermore, fats should be excluded in the early postoperative diet since they tend to slow up peristalsis and inhibit to some degree the digestion of carbohydrates. From a practical standpoint, orange juice and milk are two foods that should not be a part of the diet. With this exception, carbohydrate foods such as toast, cooked cereals, gruels, hard boiled eggs, gelatins, custards, and mashed potatoes make up an ideal postoperative diet. They form a good mass upon which the stomach can grip and push along the intestinal tract. This type of diet is now in general use on one of the surgical services at the Jewish Hospital in Philadelphia.

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SPRING CLINIC DAYS

Dates for the annual spring clinics sponsored by the Council on Scientific Work of the State Medical Society have been set for April 24, 25 and 26. Clinics this year will be held in Wausau, Watertown and La Crosse. Make arrangements now to attend one of these spring clinic days.

Formation of Urinary Calculi Following Fracture

A Case Report

By C. A. WOOD, M. D.
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I AM prompted to report the following case, first, because I believe the formation of stones in the urinary tract following fracture or long recumbency has not been sufficiently emphasized; and, second, because of the rapidity with which clinical and radiographic evidence of stone formation appeared in the case and the relative ease with which the condition was corrected.

Case Report

A married female, aged 21 years, entered the hospital on September 25, 1937, a few hours after sustaining injuries in an automobile accident. She complained of pain in the pelvic region and both legs.

Physical examination revealed the patient to be mentally alert and in considerable pain. She had abrasions of the chin, elbows and knees. There was pain on pressure over the trochanters and the lumbar region. Otherwise the physical examination was negative.

A catheterized specimen of urine taken on admission showed a specific gravity of 1.030, albumin 1+, no sugar, gross and microscopic hematuria and an acid reaction. X-ray examination on entry showed a comminuted fracture of the body and descending ramus of the left os pubis. There was marked separation of the fragments and symphysis. The ascending ramus was fractured at its junction with the acetabular portion. There was no displacement.

The patient was put to bed and the pelvis was suspended in a sling. She required catheterization intermittently for several days, at times being able to void. The urine showed a number of blood and pus cells and was acid to litmus. Hexamine and sodium acid phosphate were administered to overcome the pyuria. The urine gradually cleared. As an x-ray examination of the pelvis on November 3, 1937, showed healing fairly well advanced (fig. 1), the sling was removed.

On November 8 the patient's temperature rose to 99.4 F. She voided urine frequently in small amounts, but made no complaint of pain. On November 9 the temperature rose to 100 F. She had severe pain in the right lower abdominal quadrant and an emesis. Morphine sulfate, grain ¼, was given to relieve the pain. The pain and nausea continued.

On November 10 another x-ray examination of the urinary tract was made and the following report recorded: "Left side is clear. Right side shows stones in pelvis of kidney, also cast-like stone shadows in upper and lower ureter areas." (Fig. 2.)

On November 12 the patient's temperature rose to 104 F. and the urinalysis showed pus 4+ and a few red blood cells. I was then called in consultation. A cystoscopic examination showed the bladder mucosa to be somewhat inflamed, most acutely in the region of the right ureteral orifice. From this orifice, a grayish material was being exuded which had the appearance and consistency of freshly mixed concrete. A bougie was passed to the right kidney and, on its withdrawal, a considerable amount of this grayish material rolled out. I was unable to pass a catheter to the right kidney. Indigo carmine injected intravenously was excreted from the left ureter in five minutes; none was excreted from the right ureter in fifteen minutes. An examination of the crystalline material expelled from the right ureter showed triple and amorphous phosphates.

The patient was placed on an acid ash diet and, on November 14, cystoscopy was again performed. A no. 7 bougie was passed to the right kidney and a large amount of the gray material was again removed by manipulating the bougie.

On November 15, x-ray examination of the urinary tract was made and the following report recorded: "Slightly less calcification visible in the lower ureter and renal calices. Upper ureteral shadow appears about the same as at last examination." (Fig. 3.) Another cystoscopic examination with a no. 6 catheter passed to the right kidney obtained fairly clear urine in good volume. A smaller amount of the gray material was removed by manipulation of the bougie.

On November 22 a no. 7 catheter, passed to the right kidney, met with no obstruction and indigo carmine administered intravenously appeared in both ureters within four minutes. X-ray examination on that date was reported as follows: "Calcium deposits formerly seen in ureter are not present at this time. Remnants of the deposits seen in renal pelvis can still be seen. Right pyelogram shows generous pelvis, normal contour. Ureter shows no abnormality." The patient had no pain and her general condition was good. The urine gradually cleared of pus, and, after November 28, was free of pus cells; the acidity was maintained at a p_H of 6.4 or less throughout most of the time, although the patient had a definite tendency to produce alkaline urine. Another x-ray examination of the kidneys on November 30 was reported as follows: "The calcification formerly seen in the right kidney and ureter has entirely cleared. Definite fetal skeleton visible in left pelvis. Shadows seen in right pelvis suggestive of fetal long bones. Too far removed to be part of fetus seen on left side. May be twin pregnancy." (Fig. 4.)

The patient steadily improved and was discharged from the hospital on December 5, 1937. On February 16, 1938, she returned for reexamination. X-ray examination definitely showed a twin pregnancy. There was no recurrence of the calcium deposits formerly observed in the right pelvis. On April 30, 1938, the patient returned to the hospital and gave birth to twins.

Reports on Etiologic Factors

The etiology of stone formation in the urinary tract has not been definitely determined. Higgins and Schlumberger[1] classify the etiologic factors associated with the formation of urinary calculi as (1) infection, both local and focal; (2) stasis; (3) hyperparathyroidism; (4) nutritional deficiency; and (5) phosphaturia.

In fractures and prolonged recumbency more than one of these factors may be present in any one case. Interest in the dysfunction of the parathyroid glands has been stimulated lately; however, most authorities agree that cases of urinary calculi due to disease of parathyroid glands are rather rare. Barney and Mintz[2] state: "While hyperparathyroidism is responsible for between 4 and 5 per cent of all cases of urinary stone, the percentage of stones in the presence of this disease may be almost 70 per cent."

Griffin, Osterberg and Braasch[3] found hyperparathyroidism to be an etiologic factor in less than 0.2 per cent of 1,206 cases of urinary lithiasis. They also reported that the values for blood calcium, phosphorus and phosphatase in cases of urinary lithiasis exhibit no common change which can be termed characteristic. However, Marquardt[4] has reported that in thirty-seven cases of urinary stone the blood calcium was above normal in 78 per cent.

Several authors agree that there are so-called protective colloids in the urine which keep the salts in solution and any disturbance of the colloid balance will tend to throw them out of solution. Priestley[5] reports ". . . certain bacteria, such as Proteus ammoniae, staphylococci, and certain streptococci which split urea into ammonia and carbon dioxide, thereby creating an alkaline urine, are the organisms most commonly associated with the presence of stones." These bacteria cause a high p_H of the urine under which condition the urinary colloids are less able to maintain the crystalloids in solution.

Randall[6] states that the chemical composition of urinary stones varies according to the etiologic factor and notes that stones forming in the presence of infection producing an alkaline urine are consistently a triple phosphate deposit. He offers the theory that there are two classes of stone formation, the *primary* due to small ulceration in the kidney pelvis and the *secondary* due to stasis and infection with bacteria or debris as a nucleus.

McCague[7] emphasizes the importance of maintaining the urine at a p_H of 5 to 5.5 in preventing the formation of stones. He uses diet to maintain the acidity and ammonium chloride in addition, as needed.

Discussion and Summary

The patient described in the case report above suffered fracture of the pelvis and possibly damage to the urinary tract. After five weeks in the hospital, x-ray examination showed healing and no signs of stone formation. Six days after this examination she had typical renal colic. The following day x-ray examination showed shadows in the right ureter and kidney pelvis. The calcareous material was quite easily removed under a regimen of cystoscopic manipulation and an acid ash diet.

The calcareous material found was composed of triple and amorphous phosphates which are typically found in alkaline urine, especially when infection is present. Calcium metabolism probably had no particular influence in this case, and the only relation of the fracture to the stone formation was in the possible damage to the urinary tract with subsequent infection and the fact that it required prolonged incumbency with consequent poor drainage from the kidney pelvis.

The urine was almost consistently acid to litmus even when stone formation was present. I think this is a very important point inasmuch as most physicians use litmus paper to determine the reaction of the urine in routine examination. Litmus paper has a p_H range of 4.5 to 8.3. Urine can, in reality, be on the alkaline side and still show acid to litmus. It is advisable either to titrate to determine the p_H or use other indicators, such as methyl red or phenol red. Phosphates are precipitated in alkaline to even slightly acid urine. If the reaction is kept at a p_H of 5 to 5.5 one can be reasonably sure to avoid precipitation of phosphates.

Of course, every effort should be made to avoid infection of the urinary tract when stasis is present and catheterization required.

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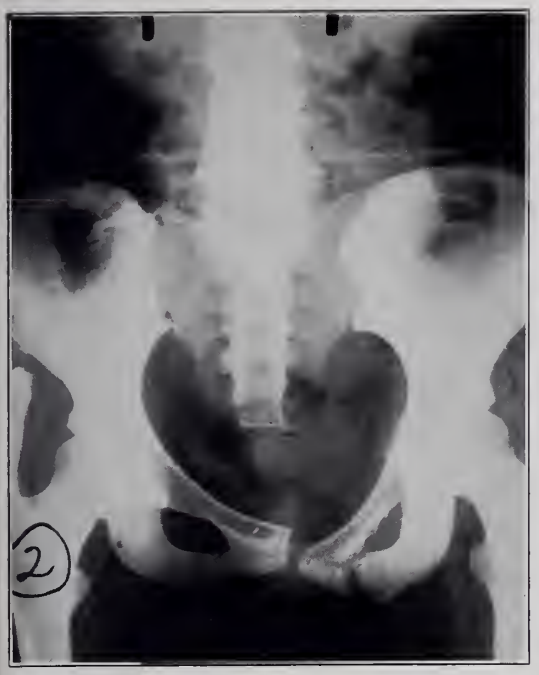

Fig. 1. Roentgenogram taken November 3, 1937, showing fracture fairly well healed and no evidence of stone.

Fig. 3. Roentgenogram taken November 15, 1937. Calcified areas much smaller in extent.

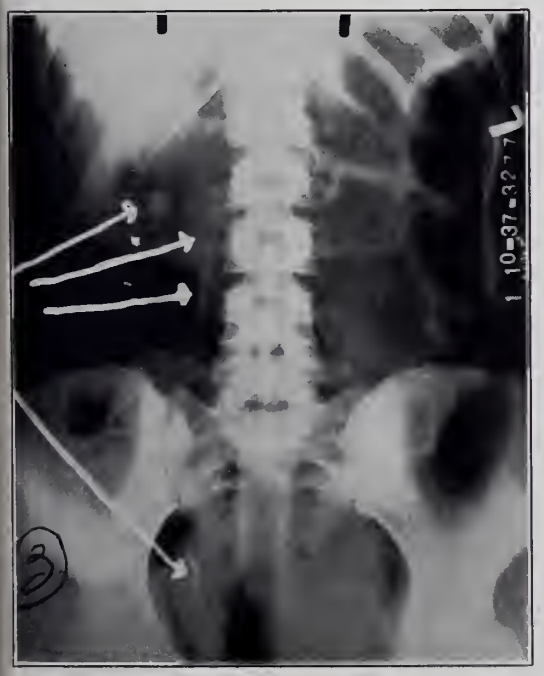

Fig. 2. Roentgenogram taken November 10, 1937. Arrows point to calcareous material in right kidney and ureter.

Fig. 4. Roentgenogram taken November 30, 1937. Calcified areas no longer in evidence. Areas of calcification in pelvis from twin pregnancy (show more clearly in original film).

Bromism*

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Oconomowoc

Historical Review

Bromine has long been a standard remedy to control those symptoms that come under the vague heading of "nervousness." It was discovered in 1826 by a French chemist, Balard, and its physiologic and therapeutic effects were described by Graf in 1838. Locock[1] suggested its use in epilepsy and the neuroses in 1857. Since that time it has been used by the medical profession for relief in the various neuropsychiatric disorders.

In late years, because of the increasing complexity of life, there has been a great demand for sedatives to help those individuals who seem unable to adjust to their environment. This demand has resulted in a flooding of the drug market with numerous sedatives, each having its own particular indications. The medical profession was quick to adopt their use and, because of the relief secured by them, the public became eager for them. A situation now exists wherein any individual may prescribe for himself and readily secure a sedative from any druggist. Some states have recently passed laws to prohibit the sale of these drugs without prescription, but there still remain the patent medicines, many of which contain bromides and the sale of which has not been restricted. Some of the more commonly known products which contain bromides are neurosine, nervine, bromoseltzer, bromo-vess, bromadonis, bromo-lithia, bromo-caffeine, Peacock's bromides, bromidia, solmides, and sedabrol. The numerous epileptic cures on the drug counters in most cases contain bromides.[2]

Bromides have long been known to produce a toxic state in an individual, a case being reported by Huette[3] as early as 1850. The use of sedatives now being generally increased, the danger of bromide intoxication becomes threatening. Reports here and abroad tell of the frequent use of the drug by patients themselves and on doctors' prescriptions.

In the Colorado Psychopathic Hospital,[4] 7.7 per cent of 1,000 patients admitted during the two-year period, 1928 to 1930, had blood bromide readings of 75 mg. per 100 cc. and over. Forty-three per cent of them received their bromide medication from doctors and 18 per cent from the ingestion of patent medicines, of which nearly 8 per cent was nervine. In 39 per cent, the source was undetermined, but it was thought to be patent medicines. Only 22 per cent of these patients sought admission to a hospital because of a recognized drug intoxication.

Gundry,[5] in a report of fifteen cases of bromide intoxication, found that nine were caused by medication taken on doctors' prescriptions and six by self-medication. In another report in the literature,[6] 4.01 per cent of 555 consecutive patients showed significant amounts of bromide in their blood. In that series of twenty-three cases of bromide intoxication it was determined that the source of the bromides was the physician in eleven cases, self-medication in five, both the aforementioned sources in three and an unknown source in four.

An analysis of admissions to the Phipps Clinic[7] over a period of six months revealed that in fifty out of 238 patients there was evidence of bromide medication. Diethelm,[8] in a report covering one year at this same clinic, writes that bromine was found in the blood of 40 per cent of those admitted. In England, where it is possible to keep a close check on all prescriptions, it was found that one in every seven contained bromine, potassium salt being the most commonly used.[9] From these reports one can gather the important place bromides have in modern medicine and the necessity of keeping in mind the dangers of bromide medication.

BROMIDE intoxication occurs when the body retains enough of the bromide radical to cause a change in the personality of the individual or the appearance of neurologic disturbances. When ingested, it accumulates rapidly in the body, even when the dosage is only 45 to 60 grains a day. Improper elimination, the presence of organic changes such as arteriosclerosis and those which produce a cardiac or renal insufficiency, encourage the retention of bromides in the body. Alcoholism, infections and syphilis also favor the production of bromide intoxication in persons using the sedative.[10, 11, 6] There also seems to be an individual susceptibility to the drug, some persons being able to tolerate more bromine without manifesting any signs of intoxication.

Pharmacology, Symptomatology, Diagnosis

Bromides, when taken by mouth, are readily absorbed from the stomach and, in a few minutes, make their appearance in the urine. However, only 10 per cent of the amount ingested can be found in the urine in the first twenty-four hours, the remainder being excreted very slowly by the kidneys. A dose of only 30 grains will not be completely excreted in less than two months. The bromide ion, after it is absorbed, tends to displace the chloride ion and, like it, is first attracted to the cells, then to the plasma where most of it will be found.[12, 13] A balance may be reached where the cell walls fail to differentiate the chlorides from the bromides. Hydrobromic acid will be secreted into the stomach along with hydrochloric acid, and bromides will be excreted by the kidneys like chlorides. However, the chlorides that are displaced by the bromides apparently are excreted by the kidneys in

* From the Rogers Memorial Sanitarium.

preference to the bromides. When there has been a 40 to 50 per cent replacement of the chlorides, death has ensued.[14, 15]

An index of the retention of bromides can be estimated by a blood analysis, and can be easily done by the Wuth comparator method.[6, 16] Normal values range from 0.5 to 2.5 mg. per cent; abnormal values may rise to 400 mg. per cent or more. Recently a case was reported in which the blood bromide level was 715 mg.[5] An estimate can also be secured from the spinal fluid, where the readings are 50 to 100 mg. below those of the blood.

The effect of the retention of the drug is most manifest in the brain and central nervous system but, because of the individual susceptibility of the nervous tissue, the symptoms and signs have no relation to the amount of bromide in the body. Most patients manifest signs of intoxication when the blood bromide stands at 150 mg. Kamman[10] quotes Thomas as reporting that the bromide content of the gray matter of the central nervous system is about 150 per cent that of the white matter when the content is calculated in milli-equivalents of bromide per gram of dry weight. The higher cortical centers are most easily influenced by the presence of bromides in toxic quantities, but the drug also produces a depression of the heart and vasomotor centers. It slows respiration, reduces body temperature and retards physical processes. The spinal reflexes are diminished. In spite of its ability to disturb the function of the nervous system to this extent, Paskind[17] found in a series of epileptic patients that there had been no deteriorating effects from bromides.

The skin contains more bromides than any other organ, but the pustules of the acne that sometimes accompanies bromism do not contain bromides. Traces of the drug are found in the milk, hair and feces.

The symptoms of bromide intoxication are many and vary according to the concentration of bromide in the organism and the individual susceptibility of the patient. The most important are those which relate to the dysfunction of the brain and central nervous system. The psychic symptoms are more apt to appear before any neurologic signs.

Restlessness is one of the earliest signs, and a particularly important one since the failure to recognize it as such in a patient under bromide therapy may result in the production of an intoxication by continuing the drug to allay this restlessness. As the disorder progresses, the patient becomes drowsy and disoriented. Loss of memory for recent events with confabulation, delirium and hallucinations occur. The hallucinations are auditory and are usually concerned with music or threatening voices. Occasionally they concern wires, electricity, boats or nets.[18] In Barbour's experience,[9] they were about large black objects, small animals, or insects.

The neurologic signs consist of diminution in sensory perception, slow and thick speech, tremors, vasomotor changes, ataxia and incoordination. Reflexes may be increased, but are usually decreased or absent. Ocular disturbances are frequent and may appear early. Diplopia, blurring of vision, disturbances in color perception and dilated pupils which react sluggishly to light are the most common. Occasionally there is a nystagmus and photophobia.

Headaches, weakness and sleep interrupted by frightful dreams are frequent complaints. The mucous membranes become dry, and following this are anorexia, fetid breath, and impaired digestion which leads to emaciation. The heart is rapid (120 to 140), sometimes irregular, and the intoxication seems to accentuate any myocardial defect. The skin is dry, an acne appearing in about 20 per cent of the cases. Upper respiratory infections are frequent. White blood cells may be increased. Curran[18] found impotence in men and menstrual disturbances in women in occasional cases.

The diagnosis can be made by a careful history and physical examination. The presence of such symptoms as restlessness, memory defect with confabulation, delirium and auditory hallucinations and the finding of thick speech, ataxia and incoordination should suggest to the physician the possibility of bromide intoxication. Curran[18] believes that the diagnosis can be made by the presence of the following syndrome: para-

phasic speech disturbance, memory defects with confabulation, visual hallucinations of objects in the distance, vestibular disturbances with ideas of being in boats and seeing nets, and occasionally micrographia, micropsia and macropsia. The determination of the bromide concentration in the blood is of decisive importance, and if this should be above 150 mg. per cent, if it is evident that the psychosis developed after the patient became intoxicated and if it clears in from two to six weeks, the physician can be certain that the bromine is the cause of the disturbance.

In the differential diagnosis one must remember that not only does bromism simulate other neuropsychiatric disorders, but also that it may be superimposed on other nervous or mental diseases. In arriving at the diagnosis one must consider alcoholic psychosis, Korsakoff's syndrome, neurosyphilis, multiple sclerosis, schizophrenia, encephalitis, epileptic dementia and intracranial tumor.

Treatment

The treatment of bromide intoxication consists of stopping the drug, encouraging elimination by forcing liquids, and the judicious use of sodium chloride. Laudenheimer,[19] in 1901, noted the effect of the intake of chlorides on bromides. Now sodium chloride is the almost specific remedy for the intoxication. The question of how much to give is still debatable. Successful therapy with only 1 gram three times a day[18, 4] is reported by some, while others would go to the extreme of 2 grams every two hours.[20] Most men dealing with these cases use from 3 to 7 grams daily.[16, 4, 21, 10, 12]

Strecker and Ebaugh[16] and others[4] have suggested that the administration of sodium chloride be withheld until the blood bromide has dropped to 200 mg., feeling that too much sodium chloride brings about a more rapid liberation of bromides from the tissues to the plasma than the kidneys can excrete. There is also the danger of damage to the kidney when the elimination of bromides is too rapid.[22]

Toenhart[11] suggests removing the bromides as hydrobromic acid by continuous aspiration of the stomach. He was able to secure 5,540 mg. of bromide in six days by this method. In such a procedure, it is necessary to replace the chlorides that have been aspirated along with the bromides. Spinal drainage has also been used in some cases.

Hydrotherapy should be used to control the disturbed behavior of the patient during treatment. During such a procedure, one should avoid the production of sweating with its loss of chlorides through the skin. If hydrotherapy proves inadequate, paraldehyde may be used, but in general, one should avoid the use of sedatives. Further treatment should be along symptomatic lines.

Case Report

The following is a report of a case of bromism recently observed in Rogers Memorial Sanitarium:

The patient, a 49 year old housewife, was brought to the sanitarium in a state of marked mental confusion. The history from the relatives revealed she had been drinking whiskey rather heavily for the past two years following the death of her mother. Three weeks before admission, she had been found in a coma following an alcoholic debauch. She was taken to a general hospital and four days afterward became confused. In the next few days she displayed marked restlessness, and it was apparent that she was having hallucinations. Her condition became such at the end of two weeks' stay in the hospital that it was necessary to move her to the sanitarium. On questioning the relatives at length, it was finally brought out that, beside using alcohol, the patient had been taking large quantities of bromide and had even managed to get some into the hospital without the knowledge of the physicians. At the time of her admission, it was evident that she was disoriented in all spheres, but there were no hallucinations. She had markêd ataxia and dysarthria.

Physical examination at this time revealed irregular pupils, dry mucous membranes of lips and mouth, an inflamed pharynx with exudate, weak pulse and absent tendon reflexes. There was also a portal cirrhosis with ascites. Laboratory reports revealed a blood bromide of 325 mg. per cent and albuminuria.

Treatment consisted of fluids, controlling the restlessness with hydrotherapy and paraldehyde, and bed rest. In two weeks, under this regime, the blood bromide dropped to 250 mg. per cent, and there was evident a transitory clearing of the sensorium. In another two weeks, the blood bromide concentration dropped below 200 mg., but there still remained some mental confusion. At this time sodium chloride, 1 gram three times a day, was started, and after ten days of this, the patient was noticeably less con-

fused but still ataxic and unable to speak clearly. Her blood bromide at this time had dropped to 100 mg.

After two weeks' use of sodium chloride and six weeks in the sanitarium, there was a sudden clearing of the sensorium. The patient became perfectly oriented, and the dysarthria disappeared, all in the course of twenty-four hours. The patient's blood bromide at this time was 90 mg. The progress from this point was rapid, and the patient left the sanitarium in ten days.

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Improved Technic in Use of the Kielland Forceps*

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Marshfield

THE purpose of this paper is to offer an improved method in the rotation of the head by the Kielland forceps. This change in technic prevents many of the complications and injuries to the mother that have caused so many arguments against the use of this type of forceps.

Professor Christian Kielland of Norway first presented this forceps in a paper at Munich in 1915. He designed the instrument in 1908 and with it by 1915 had delivered 392 women with excellent results.

There are several marked differences in its construction from any other obstetrical forceps.

1. It has only a slight pelvic curve.
2. The shank is longer and narrower.
3. It has a sliding lock.
4. The concavity of the instrument starts directly from the shank.
5. The construction is much lighter.

Its advantages are as follows:

1. It fits closely to the head and this fact combined with the slight pelvic curve allows it to be used as a rotator.
2. It can always be applied in a biparietal diameter regardless of the position of the head.
3. The application is made easier than with any other forceps.
4. The sliding lock allows a perfect application in cases of anterior and posterior asynclitism.
5. When the proper application has been made, the instrument never slips and rarely causes compression of the head because the pressure, if any, is in most cases on the malar bones.

* Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

The disadvantages that have been reported are:

1. Rupture of lower uterine segment.
2. Serious cervical lacerations.
3. Separation of the placenta.
4. Vesicovaginal fistulae.
5. High deep lacerations of vagina at times resulting in severe hemorrhage.
6. Second and third degree lacerations of the perineum.
7. Compression of umbilical cord between the head and the forceps.
8. Intracranial hemorrhage.

Cases of uterine rupture, cervical laceration and vesicovaginal fistulae are nearly always the result of faulty obstetrics. Separation of the placenta by the forceps will not happen if the wandering method of application hereinafter described is used. The vaginal lacerations can be prevented by the improved method of rotation. The perineal lacerations can be prevented by episiotomy, slower rotation of the head and slower extraction. In the wandering method of application the cord is never compressed between the head and the forceps. Intracranial hemorrhage and death of the baby are usually the result of attempting delivery when there is marked disproportion between the size of the head and the pelvis or when delivery is too rapid.

The Kielland Technic

Dr. Kielland offers two methods of application: (1) a method in which the anterior blade is inserted under the symphysis and rotated in the uterus, and (2) the wandering method. There are certain requirements that must be met before application of these forceps:

1. An accurate diagnosis of position of the head must be made.
2. The cervix should be fully dilated.
3. The upper or anterior blade should be selected as it is always the first one to be applied. To do this, the forceps should be locked and placed before the vulva in the position it is to assume when applied, the concave margin of the blades being toward the leading point of the head. The anterior part of the instrument is to be grasped by the lower end of the blade, as this avoids any possible chance of selecting the wrong blade.

The discussion of the method of applying the anterior blade under the symphysis is purposely omitted in this paper as it offers no special advantages. Also this application may rupture the lower uterine segment, separate the placenta or bring down a loop of umbilical cord between the head and the forceps.

The wandering method of application is the one that we have used at the Marshfield Clinic for fourteen years and with which we have never experienced any serious difficulties or accidents. For example, let us assume that we have a deep transverse arrest of the head with the occiput to the left. The forceps is locked and held in an anterior posterior position directly in front of the vulva, with the concavity of the margins of the blades to the mother's left. Small buttons have been placed on the handles to indicate this concavity or front of the forceps. The upper blade is now selected by grasping the lower end of the blade. Two fingers of the right hand are inserted between the head and the cervix. The upper blade is grasped in the left hand like a sword and is passed between the fingers of the right hand and the head, starting first in a vertical position and sweeping around the head. As soon as the lower end of the blade has reached the tips of the fingers, they are used as a fulcrum and the handle depressed. This maneuver carries the blade nearly to the biparietal diameter and a slight direct push of the fingers moves the blade to an anterior position directly over the parietal bone.

Occasionally during this maneuver the occiput travels with the blade to an anterior position and the instrument will then be directly over the occiput. This rotation of the occiput to an anterior position would seem to be a fortunate occurrence, but almost invariably as the blade is removed the occiput rotates back to the tranverse position. If this occurs on a second application, the application has to be reversed, that is, left hand between cervix and head on mother's right side, the blade held in the right hand passed around the forehead in the same manner as over the occiput. We

have never seen the forehead follow the instrument.

The posterior blade is inserted directly posterior to the head. As soon as the promontory of the sacrum is reached, the handle must be depressed. At times it is not possible to pass the instrument directly posteriorly and it can then be passed either to the right or left of the center and pushed directly posterior by the fingers. The blades are then locked. Often it is found that one blade is higher than the other, which need cause no concern as they adjust themselves as soon as traction is made.

According to the Kielland technic, as soon as the blades are applied and locked one or two tractions are made. The handles are then grasped firmly, and the head is rotated with one sweep of 90 to 180 degrees. Then a rapid extraction is done. If the pelvis is roomy and the head small, very little damage will be done, but in most cases the head fits tightly and is firmly grasped by the vaginal wall. In such cases it is impossible for the vaginal wall to slip away from the head fast enough and the results are numerous, deep, high lacerations of the vaginal wall. Some of these extend to the cervix and are accompanied by severe hemorrhage. They are all very difficult to repair and are a possible source of postpartum infection.

Modification in Technic

We have modified this method as follows: By intermittent tractions the head is brought down to the hollow of the sacrum. No attempt at rotation is made until this position is reached; however, during the descent of the head some spontaneous rotation is nearly always accomplished. A posterior occiput usually rotates to a transverse position.

The handles are now loosened and shaken slightly, then grasped firmly and an anterior rotation of not more than 3 to 5 degrees is made. The handles are now opened for a short interval, then relocked and a slight traction is again made, but not with the intent of advancing the head. The handles are again loosened, shaken again, closed, grasped firmly and the head is rotated another 3 to 5 degrees. This maneuver is repeated until the occiput is rotated to an anterior position, regardless of time, unless the condition of mother or baby is unsatisfactory.

The head is now extracted, care being taken not to elevate the handles as with an ordinary forceps, as this will cause the blades to slip up over the forehead.

This method allows the vaginal wall to slip away without tearing and also lessens the danger of intracranial hemorrhage of the baby, which is always present in a rapid rotation and extraction. There are very few occasions for speed in obstetrics, and certainly a forceps delivery in most cases is not one of them.

I wish to offer one criticism of the present day obstetrical teaching. Most medical schools either ignore the Kielland forceps or teach its use in a haphazard and indifferent manner, usually at the same time advising the student to leave use of the instrument to the experienced operator. I am certain that the mother and baby are less liable to injury, when the head is in a posterior or transverse position, with a young practitioner well trained in the use of the Kielland forceps, than with any other type of instrument.

Conclusions

1. The application of the Kielland forceps can always be made in a biparietal diameter regardless of the position of the head.

2. The instrument when properly applied never slips and rarely causes compression of the head.

3. The forceps can be used as a rotator due to the fact that it has a slight pelvic curve and fits closely to the head.

4. If, instead of the Kielland method of rotating the head, a slow rotation is made when the head is in the excavation of the pelvis, the damage, if any, to the mother and baby will be very slight.

REFERENCE

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Treatment of Atrophic Arthritis

By ARTHUR C. HANSEN, M. D.
Milwaukee

Historical Survey

In 1936 an editorial review of the present status of the rheumatic diseases in the Journal of the American Medical Association* stated: "Substantially nothing has been added recently to knowledge of etiology or treatment of either disease (atrophic and hypertrophic arthritis). The only advance has been in tolerance of most writers for the views of others; this open-mindedness, in a field in which nobody knows much, is a necessary prerequisite to acquirement of knowledge." That statement still holds true today.

Arthritis remains a challenge despite the fact that its antiquity extends farther back in medical history than any other disease. Evidence has been found that it existed in the bones of prehistoric animals in the Mesozoic age a hundred million years ago, the ape-man two million years in the past, and the Java and Neolithic man. The disease was well known in ancient Egypt. Mummies found in Egyptian tombs as early as 1300 B.C. show the same arthritic changes which are typical of the disease today.

Arthritis has been referred to as one of the great scourges of the world. England, Germany, Sweden, and other European countries have an immense invalidity from this disease. The same is true of the United States and Canada. Among 16,000,000 persons carrying health insurance in England there are annually 400,000 with rheumatic disease. In the state of Massachusetts 12 per cent of the people are suffering from rheumatism. The 140,000 persons so afflicted are in contrast to the 84,000 with heart disease, 16,000 with tuberculosis, and 11,000 with cancer. It has been estimated that there are over 3,000,000 chronic arthritis patients in the whole United States. Arthritis exacts an annual loss of more than 7,500,000 weeks of work with a consequent economic loss of more than $200,000,000 yearly. No wonder the United States Public Health Service has listed it as "Public Health Enemy No. 10."

Types and Treatment

THE two principal forms of chronic arthritis are (1) atrophic arthritis, which is considered synonymous with arthritis deformans, chronic infectious, or rheumatoid arthritis, and (2) hypertrophic arthritis, synonymous with chronic senescent, degenerative, or osteo-arthritis. Atrophic arthritis occurs fairly early in life, some time between the ages of twenty and fifty years. Hypertrophic arthritis is more likely to occur later in life, from the age of fifty on.

Naturally the treatment of any condition of unknown etiology is difficult. This is particularly true of atrophic arthritis. Since arthritis is a systemic disease with local manifestations in the joints, it is necessary not only to treat the joints in particular, but also the body as a whole. As the situation stands today there is no simple cure for arthritis. The patient who expects a quick recovery or relief from some magic panacea poured out of a bottle will be disappointed. Each patient is an individual problem and no one form of treatment can be applied successfully in every case. However, favorable results may be expected in 50 to 80 per cent of the patients treated in the early stages, and a majority of patients in this group should be restored sufficiently to be able to carry on their usual work.

Rest.—Rest is undoubtedly the first and most important single factor in the treatment of atrophic arthritis. Too much stress cannot be laid upon the necessity for mental as well as physical rest—rest from the cares of business and freedom from every emotional strain. The patient with atrophic arthritis is likely to be of the asthenic type. He tires easly; he suffers from chronic exhaustion. As an aid in the conservation of his energy he should spend at least ten hours a night in bed. Curtailment of social activity is advisable.

During the acute stage of atrophic arthritis the patient must be kept in bed. Then as the process subsides he may be allowed up for short periods each day. At the earliest possible moment, joint-use should be started to prevent stiffening and contracture. This can be done by putting each joint through a complete range of motion one or more times daily.

Diet.—The relation of diet to arthritis is probably the most controversial phase in the whole treatment of arthritis. In the past, almost every type of diet was advocated. Today we know that an incorrect diet does not cause arthritis and arthritis cannot be cured by correcting the diet alone. In the light of more recent knowledge a reduction of the carbohydrates in the diet is recommended.

* The present status of rheumatism. J.A.M.A. 106: 1900 (May 30) 1936.

Investigation suggests the rationale for carbohydrate reduction lies in the increased consumption of vitamins and minerals that goes with the consequent increased intake of protein and fat. Meat and the so-called "acid" fruits are no longer taboo. In general, the chief consideration should be to provide a high caloric diet, well balanced and containing the proper proportion of the various elements which are necessary to maintain good health. Improvement is usually noted in the undernourished arthritic patient as the weight increases.

Since there is reason to suspect that a relative vitamin deficiency exists in many patients with atrophic arthritis, the diet is also supplemented with vitamins. Vitamins A and D are given in the form of cod liver oil, the dose being one ounce twice daily. If this cannot be taken, halibut liver oil with viosterol may be substituted. The addition of vitamin B to the diet is excellent for its tonic effect. Many forms of vitamin B are now available.

Bowel management.—It has been observed that joint symptoms can be aggravated by inadequate elimination. This phase of treatment is too often neglected. Drastic cathartics are not necessary. A proper diet with plenty of roughage and plenty of water may be sufficient. If necessary, mineral oil, cascara, sagrada, or some mild saline cathartic is employed. The inclusion of vitamin B in the diet aids in improving the tone of the bowel. Colonic irrigation is of doubtful value.

Focal infection.—It is difficult to decide just what role focal infection plays in atrophic arthritis. To gain the maximum amount of benefit the focus must be eradicated during the early stages of the disease. The benefit from such removal decreases with the length of duration of the arthritis. Although the clinical results after removal may be disappointing, it is unwise for any patient with atrophic arthritis to retain any infection in the body.

Diseased teeth and tonsils are the most widely recognized sources of foci of infection, the others being the nasal sinuses, bronchial tubes, intestinal tract, gallbladder and appendix, the prostate and seminal vesicles in men, and the uterus and adnexa in women. However, eradication of these original sources of infection does not immediately suppress the secondary foci that might have developed in regional lymph nodes or in joint structures. These ofttimes can be eliminated only by building up the systemic resistance of the patient.

It is well to remember that the removal of any infective focus may be followed by a temporary exacerbation of the arthritis. If there is likelihood of severe shock from the surgical procedure in a debilitated patient, the operation had best be preceded by a period of weight gain and rest.

Vaccines.—The use of vaccines in the treatment of atrophic arthritis is another mooted question. Vaccine therapy is based on the assumption that the arthritis is caused by an infection of bacteria of low virulence. The organism most frequently found is the streptococcus. A vaccine may be made from a septic focus found in the patient and thus be autogenous, or it may be a stock mixture of a number of strains from various cases. The intravenous method of introduction appears to be the one of choice since it has been shown that the blood agglutinins are thus augmented while the hypersensitivity is not. This latter fact is important, if, as many believe, hypersensitivity to bacterial proteins is an important factor in the etiology of arthritis.

In general, it may be said that those patients with sedimentation rates of 30 mm. or more in one hour and low agglutination titres will be benefited by vaccine therapy.

The danger of the indiscriminate use of vaccines lies in the possibility of their use to the exclusion of more effective agencies.

Transfusion.—Transfusions have a worth while place in the treatment of early atrophic arthritis. The beneficial results have sometimes been very dramatic. In chronic cases no results have been noted.

Drugs.—Of all the drugs used in the treatment of atrophic arthritis for the relief of pain, acetyl salicylic acid is the best. If this alone is insufficient, it may be com-

bined with phenacetin and caffeine. In severe cases the addition of codeine is helpful.

Since one of the common findings in atrophic arthritis is anemia of the iron deficiency type, iron therapy in the form of ferric ammonium citrate or ferrous sulphate is indicated. When there is an associated achlorhydria, dilute hydrochloric acid is indicated.

Arsenic is a most valuable drug. It is efficacious in improving the well-being of the patient. It can be given in the form of neoarsphenamine in doses of 0.3 to 0.45 gm. twice a week for ten to twelve injections.

When there is a low metabolic rate, thyroid is sometimes given. Again this is not specific therapy, but intended only to aid in building up the patient.

The use of massive doses of vitamin D has not proved as successful as first claimed. Doubt as to wisdom of giving daily doses of from 250,000 to 600,000 U.S.P. units of concentrated vitamin D, when the effect on human tissues is undetermined, has been expressed.

Colloidal sulphur is being injected both intramuscularly and intravenously, the theory being that there is a disturbance of sulphur metabolism with a deficiency of this element in the joint cartilages. This disturbance can be detected by the cystine content determination of the finger nails. Some of the claims for sulphur appear to be too extravagant, particularly in view of the negative results of more conservative investigators. Those patients showing improvement also received other forms of treatment.

Gold salt therapy has never reached the popularity in this country that it has in England and France. Its use has been confined to atrophic arthritis. The mode of action is unknown. Contraindications to gold are the presence of severe diabetes, nephritis, hepatitis, marked hypertension, or hemorrhagic tendencies. Frequent and rather serious toxic reactions occur even in the best of hands. This has quelled enthusiasm for the drug by American rheumatologists.

Physical therapy.—Physical therapy is a very important adjunct in the treatment of atrophic arthritis. Heat, in whatever form it is applied, has only one purpose—to promote healing by improving the circulation to the joint. The patient should be taught home physiotherapy. A baker such as is recommended by the Council on Physical Therapy of the American Medical Association can be built very cheaply, and an excellent radiant heat lamp can be constructed by substituting a 250 watt Mazda CX infra-red bulb for the heating element in an ordinary electric bathroom heater. In the treatment of the feet, ankles, hands and wrists the paraffin bath has particular advantages. It enables a higher temperature to be applied than with any other form of heat. The resulting relief from pain lasts longer and the return of the joint to normal is more rapid.

Massage also is directed toward opening the vascular channels of the arthritic joint and thereby increasing the circulation. In early arthritis massage is contraindicated, as is heavy massage over a joint in the later stages. The danger lies in an increased local reaction. Superficial stroking is started over the joint in addition to the kneading massage above and below the joint. This should be preceded by at least fifteen minutes of heat and should be given for ten minutes twice a day.

Exercise should be begun gradually and must never be carried to the point of fatigue. Its purpose is to prevent stiffening and to help redevelop atrophied muscles. Active, forceful movements cause pain and endanger their usefulness.

In the main the factors just mentioned constitute the treatment of atrophic arthritis. Authorities differ in their opinions as to the value of special forms of treatment, but they do agree as to the general measures.

Summary

Despite the fact that there is no specific therapy for atrophic arthritis, the coordination of treatment does improve the prognosis and tends to lessen materially the disability.

The problem of atrophic arthritis (and this is true of any one of the rheumatoid diseases) must be met by the general practitioner. It is he who is first consulted. Upon him rests the responsibility of early diagnosis and the institution of proper therapy.

Dr. William Snow Miller

By W. J. MEEK, PH. D.
Assistant Dean, University of Wisconsin Medical School, Madison

ON DECEMBER 26, 1939, occurred the death of Dr. William Snow Miller, professor emeritus of anatomy in the University of Wisconsin Medical School. Dr. Miller was not only the oldest member of the medical faculty in years but also in length of service. He came to the University in 1892 as instructor in zoology, and he remained a trusted teacher and a brilliant investigator for forty-seven years.

William Snow Miller was born at Stirling, Mass., March 29, 1858, the son of William and Harriet Emily Snow Miller. The father was a Congregational minister and a man of ability. The son received his elementary education at Williston Academy. At one time he considered entering the army but finally decided on a medical career. He entered the medical school of Yale University and was graduated from that school in 1879. For a time he remained there, serving as demonstrator of anatomy. Later he entered private practice. Slowly increasing deafness as well as his own desires turned his attention to laboratory work. While serving as pathologist to the Memorial Hospital at Worcester he entered the newly founded Clark University as fellow.

In 1892 he was called to the University of Wisconsin as instructor in vertebrate anatomy. His stay in Wisconsin was broken only by three leaves of absence. The year 1895–1896 he spent in Leipzig. In 1902 he was a fellow at the Johns Hopkins University in Baltimore and in 1918 he was a lecturer at the same institution. In 1924 he became professor emeritus of anatomy. He had no thought of retirement from research, however, and the last fifteen years were the most productive of his life.

In 1881 Dr. Miller was married to Miss Carrie M. Bradley who died in 1901. In 1912 he was married to Miss Alice L. Burdick of Madison, who survives him.

The widespread recognition of Dr. Miller's ability and influence as a scientist is

attested by the memberships he held in many societies. He was a fellow of the American Medical Association and an honorary member of the state medical societies of Connecticut and Wisconsin. He was a fellow of the American Association for the Advancement of Science and a member of the American Association for the History of Medicine, the Medical History Society of Chicago, the State Historical Society of Wisconsin, the Institute of Medicine in Chicago, the Milwaukee Academy of Medicine, the American Society of Naturalists, the American Association of Anatomists, the National Tuberculosis Association (honorary), the Wisconsin Academy of Sciences, Arts and Letters and the Harvey Society of New York. Abroad he was enrolled in the Deutsche Gesellschaft fur Geschichte der Medizin and the Societe International contre la Tuber-

culose. He was also a member of Sigma Xi, the medical fraternity Phi Beta Pi, Acacia and the Masonic order.

In 1920 he was given the honorary degree of Doctor of Science by the University of Cincinnati. In 1926 the University of Wisconsin likewise honored him with the same degree. He was also a recipient of the coveted Trudeau medal for his contributions to our knowledge of tuberculosis.

Dr. Miller's reputation, which was truly great and international, rested on two things: first, his contributions to our knowledge of the anatomy of the lung; and second, his interest and accomplishments in the field of medical history.

As the result of forty years of intensive research he established himself as the outstanding authority, both at home and abroad, on the structure of the lung. His results were due to a most penetrating mind and an unusual skill in making microscopic preparations and reconstructions. The modern conception of the lung lobule is Miller's. His accurate knowledge of lung structure was applied to the problems of tubercle formation and the spread of tuberculosis in the lung. This is not the place to describe these beautiful and important researches. So important were they, however, that the National Tuberculosis Association made possible their collection into the monograph on "The Lung" which appeared in 1937. It is not often that a work of science proves to be a best seller but such was the case with this volume. The edition was sold out immediately and copies are already rarities commanding a premium. The book is destined to be one of the classics of anatomy.

Dr. Miller's researches ceased only with his death. At a dinner given in his honor a few years ago by the Dane County Medical Society the writer remarked that as long as there was an active cell in Dr. Miller's brain it would be speculating on lung structure and where Dr. Beaumont was in 1813. The prophecy was true. In his last illness he still spent a few hours each day with drawings and reconstruction of an entire fetal lung.

While Dr. Miller had a certain interest in music, politics and sport, his great avocation was the history of medicine. So important did he think this was for the cultural side of medical men that early in his teaching career he began a collection of old anatomies and works on the history of medicine. Thus was born his splendid library and the "Miller Historical Seminar." This was the first attempt in America seriously to bring the history of medicine into line with medical education. The seminar not only played a great role in Dr. Miller's life, but it became an institution of the University of Wisconsin Medical School. For many years it was attended largely by medical student or graduate assistants in the department. In later years after his retirement from active teaching, its members became mostly older colleagues in the medical school. The fruits of these winter evenings are contained in a set of large manuscript volumes. The separate papers range through the whole field of medical history. Among the best are Dr. Miller's own original articles on William Beaumont, Elisha North and early Wisconsin Medical History. Many of the seminar papers have been printed in various historical journals. It would be impossible to mention all of the young men, many of whom are now distinguished, that passed through the Miller seminar. Without exception each has attributed a part of his success to the moulding influence which emanated from the leader of the group. It was in recognition of this interest in students and history that Phi Beta Pi established the Miller Lectureship.

In Washington, D. C., at the January meeting of the Committee on Research of the National Tuberculosis Association, the following resolutions were passed while the members stood in memory of Dr. Miller.

WHEREAS, The Committee on Medical Research of the National Tuberculosis Association has heard with sadness of the death of William Snow Miller at Madison, Wis., and

WHEREAS, For years it has been closely associated with Dr. Miller's exquisite work on the anatomy of the lung and was honored to have him receive the first grant the committee ever made, be it therefore

Resolved, That the Committee on Medical Research desires to express to Mrs. Miller the sincere sympathy of each of its members and to say how deeply they feel the loss of so brilliant a student and the ending of so useful a life.

(Continued on page 145)

Comments on Treatment

EDITORS
A. J. Quick M. D., Marquette University, Milwaukee
and
M. H. Seevers, M. D., University of Wisconsin, Madison

Human Convalescent Serum in the Prevention and Treatment of Scarlet Fever

Human convalescent scarlet fever serum is obtained from the blood of convalescing scarlet fever patients. The serum from various patients is pooled after sterility and serological tests for syphilis on the individual specimens have been found to be negative. It can be used subcutaneously, intramuscularly or intravenously without danger, if care as to administration is taken. The needle and syringe should be sterilized in clean utensils and in boiling distilled water. Overheating the serum will coagulate it.

Passive immunity lasting from ten to fourteen days apparently can be obtained by the intramuscular injection of this agent. The dosage commonly used is as follows:

Infants and young children	10 cc.
Older children and adults	20 cc.

After a susceptible person (Dick positive) has had intimate exposure to scarlet fever, he may be given convalescent scarlet fever serum immediately for temporary protection. If he stays in contact with the scarlet fever patient, it is probably wise to repeat the injections every ten days. If he is removed from the patient, an attempt may be made to immunize him with scarlet fever toxin or toxoid before returning him to the opportunity of intimate exposure.

A most satisfactory program for the treatment of scarlet fever has been carried out at South View Hospital since convalescent serum has been available in Milwaukee.* After the intravenous injection of the proper amount of convalescent scarlet fever serum, the patient's clinical condition rapidly improves in most cases. The temperature frequently drops rapidly and the angina improves in twelve to fourteen hours. Analysis of our results demonstrates that the complications of the disease are less by one-half after its use. Clinical judgment determines the severity of a case of scarlet fever and the need for serum. However, it must be pointed out that complications frequently occur even in the milder cases. The best results are seen when the patient receives the serum early in the course of the disease. Recent results tend to show that sulfanilamide is unsatisfactory for the initial toxic phase of scarlet fever. It may be of decided advantage in the treatment of complications. Additional convalescent scarlet fever serum may be given without fear of severe reactions.

The recommended therapeutic dosages of convalescent scarlet fever serum are as follows:

	Moderate Cases	Severe Cases
Infants	20 cc.	20– 40 cc.
Children	20–40 cc.	60 cc.
Adults	40–60 cc.	80–100 cc.

Related miscellaneous hemolytic streptococcus infections resembling some manifestations of scarlet fever seem to respond frequently in a satisfactory manner to convalescent scarlet fever serum.—Max Fox, M.D., Milwaukee.

* Milwaukee Convalescent Serum Center, Columbia Hospital, Milwaukee, Wisconsin.

AMERICAN BOARD OF OPHTHALMOLOGY

Oral Examination: New York City, June 8 and 10. Fall examination to be announced later.

Case Reports: Candidates planning to take June examination must file case reports before March 1.

For application blanks write to Dr. John Green, 6830 Waterman Avenue, St. Louis, Missouri.

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« « « EDITORIALS » » »

99th ANNIVERSARY MEETING, STATE MEDICAL SOCIETY OF WISCONSIN
September 18, 19 and 20, 1940, Milwaukee

Diodrast Reactions

TO PREVENT possible serious reactions to diodrast, the use of which is mentioned by Dry on page 92 of this issue, Dolan* has suggested testing patients for sensitivity to this x-ray resistant substance.

The history of allergy of any patient who is to receive an injection of the drug should be thoroughly investigated, he says. If a history of allergic sensitivity of any kind is obtained, he has the patient hold a small amount of the drug in the mouth for ten minutes. If no reaction occurs in this time the patient swallows the solution. After thirty minutes a check is made and if no reaction is found the injection is made.

Dr. Dolan says he has reported to the manufacturers the adverse reactions found by him and suggested they include in their literature the warning that "diodrast" or a similar product, skiodan, should not be injected in veins of patients with asthma or iodine sensitivity.

* J.A.M.A. 114:138–139 (Jan. 13) 1940.

Bromide Intoxication

BROMISM, discussed by Clark on pages 100 to 103 of this issue, is now a common condition in all parts of the United States according to reports in the literature and, as Clark states, is one which physicians should keep in mind. Gundry, quoted by Clark, declares that improper use of physicians' prescriptions by disregarding instructions and taking large frequent doses, and repeated refilling of a prescription which calls for a moderate dose of bromide, together with self medication through the many proprietary medicines containing bromides, are the chief causes of the condition. As preventive measures, Gundry recommends that all prescriptions be marked "not to be refilled" and that the public be warned against self medication.

"A Long Way Off"

IN HER weekly column in The Progressive of December 30, 1939, Mrs. Philip F. La Follette, wife of our former governor, was discussing unemployment ills, the federal efforts and expenditures when she said:

"I can't help feeling that Washington is always a long way off, not only by geography but also in thought, from the mass of the people. All too often when I talk to the extremely able people down there I get the sense that they are living in a vacuum with their blue-prints and plans; that they are sincerely trying very hard to find a solution to our difficulties but somehow they need to get out into the countryside and re-see nature and the mass of their fellow human-beings."

It was the truth of this statement that led our Society two years ago to make a first hand study of health needs in Wisconsin, not from statistical tables but after across-the-table-talks with people from all walks of life and in thirty-nine of Wisconsin's seventy-one counties. Disease occurs in people and not in cartons. The physician must treat disease where it occurs and his efforts in the field of prevention must encompass the whole welfare of the thousands of individuals that go to make up Wisconsin's population.

In all of our health plans and planning, if we for one moment lose sight of the individual physician and his individual patient, we are apt to think that if we just do this or just do that, a whole problem will be solved. And, in that type of plan, too frequently there is failure on the part of those who are removed from the day-by-day experience with life itself to realize that education has a great role to play, — now and forever in the future.

In the field of health, too often the ignorance of a person or parent, the unreasoned or illogical fear of a surgical procedure, the upkeep of the car but neglect of the human machine, the unwillingness to admit that something is probably "out-of-gear," the acceptance of health and reluctance to think of disease except when something happens, superstition itself,—these and many other factors are all basic facts that charts fail to reveal. And plans and blue-prints made without the basis of medical knowledge and experience are even more apt to lead to failure and actual retreat than battle-maps made without knowledge of the terrain.

Mrs. La Follette has put her finger upon the reason why medicine constantly emphasizes that plans must be made to meet existing local conditions; why funds must be administered under local direction by those who know the local needs and problems.

The writer's father once made the point in a different fashion when he pointed out that complaints as to a local condition could be voiced by the complainant in person to the official in charge; that complaints as to a condition governed by state officers too often required aid from an attorney at Madison, and complaints as to conditions governed by federal authorities had best be forgotten if the official in charge did not act upon the basis of the first letter.

THE PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association advocates:

1. The establishment of an agency of federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

Funds are needed ofttimes in the battle to improve health conditions of our people who were described by the Surgeon General of the U. S. Public Health Service on January 1 as the healthiest generation in the healthiest country in the world. But, if we are not to enter upon a state of confusion resulting in retreat or disaster, those funds must be applied in the amount required to meet local conditions and administered under plans made by those who understand the health terrain on which the battle is to be fought. We cannot afford to have the plans made by sincere people who live in a vacuum of unrealities.

Change in Type

READERS of this issue of THE JOURNAL may wonder at the change in type-size in several of its scientific articles. This change —a continuation of which is contemplated— is based on a careful survey of past issues, made with the idea of increasing THE JOURNAL's readability and available space.

The survey reveals that most of the scientific articles contain anywhere from one long paragraph to four or five shorter ones, devoted, not so much to a description of new work and discoveries, as to the laying of a foundation for it by giving references to previous work in the field.

This is a feature of medical literature generally and one approved by leading medical editors, when the references are chosen with discrimination. Fishbein[1] writes: "Hardly any one detail of a well prepared and well written article will give a better and clearer idea of a writer's methods or foster greater confidence in the accuracy and soundness of his views than well chosen, well arranged, absolutely correct references." He warns, however, against giving complete reviews of the literature in ordinary periodical articles and advises in such articles only the use of references which illuminate the subject under consideration. The late editor of the Mayo Clinic publications, Mrs. Maud H. Mellish,[2] with a terseness characteristic of her, said, "Don't go back to the Garden of Eden and review the literature to date." Her caution was not intended, of course, for the true historical review or digest.

In one sense, reference material is a synopsis to give the reader of a continued story the high lights of chapters that have gone before. Yet, when it appears in an ordinary periodical article in the same type as the new chapters, it is given similar prominence and space, and frequently starts the article with a deadly dullness.

By publishing synopsis material in 8-point solid type and new material in 10-point leaded type, the editorial board hopes to (1) increase, at no extra cost to the Society membership, the educational value of THE JOURNAL, by making available more space for scientific articles; and (2) serve the reader who wishes to start at once with fresh material as well as the reader who wants to know of previous work.

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1. Fishbein, Morris, and Whelan, Jewel F.: Medical writing. Chicago: American Medical Association, 1938.
2. Mellish, Maud H.: The writing of medical papers. Ed. 2, revised. Philadelphia: W. B. Saunders Company, 1925.

"Healthier on This Side . . ."

UNDER the caption "Healthier on This Side," the *Evening Telegram*, newspaper of Superior, Wisconsin, carried, on January 16, the following comment on health in the United States:

"Both the general death rate and the infant mortality rate in the United States hit new lows in 1938. The figures for that year are the latest which have been compiled. How the nation's health was rated last year will not be known for some time. But of one thing Americans can be certain— both immediate health and prospects of longevity look a good deal better on this side of the Atlantic ocean than they do on the European side.

* * *

"Americans should be proud that conditions in this country make it possible for scientists to proceed with their humanitarian works. They are still free to work in their laboratories along lines they have chosen. They are not compelled to bend their talents toward finding new processes to destroy, new formulae for war.

"Their job of saving humanity has not yet become a futile farce. Their work is not a profanity of life. They do not need to save lives so that the products of other scientists and inventors can snuff out those lives on battlefields. American scientists are too busy with the art of life to bother with the arts of death. Nothing they do will be wasted as long as the rank and file of us keep conditions that way."

. . . . THE PRESIDENT'S PAGES . . . .

1841—1941

IN 1841 William Henry Harrison became president of the United States, died and was succeeded in office by John Tyler. In 1841 James Duane Doty was territorial governor of Wisconsin; the Mormons had arrived in Illinois; and the Brook Farm community started in New England. The same year saw about the last of Robert Owen's experiment in community life at New Harmony. Owen believed there should be no social grades and everyone should be equal in all respects to everyone else. In his plan, clothing and wages were to be the same; every man was to labor according to his ability and to receive the necessities of life thereby. Owen believed all men wanted to work as a matter of self-respect, but, before his experiment in economics was over, he found that many people are sadly lacking in self-respect.

All this and more happened a hundred years ago and members of the Society who are today wrestling with problems of medical care, social security and community enterprises in general can well afford to take a few minutes to read about the problems that were with our people at that time. If our present date line were pasted at the head of items on these problems, a reader not familiar with them might easily be led to believe he was reading today's newspaper.

In those very similar times, in 1841, our State Medical Society of Wisconsin received its charter. Our country has fought six wars since that time and we as a Society have actively and collectively fought a war against disease,—so effectively that Wisconsin has the great honor of being one of the three leading States in the Union in health achievements.

In a hundred years we have done much to increase the span of life, so much in fact that now we sit back and wonder whether the State can stand the consequent increase in old age pensions. In 1900 there was one person of 60 years in every twelve. By 1960 there may be one in every six,—and that is something to think about, one-sixth of the population 60 years of age or over.

In increasing the life-span we have probably contributed to the fact that cancer has risen to second place among causes of death in the United States. The total dead for all our wars numbers something like 170,000 people. In the last fifteen years, actual deaths by automobile have amounted to over 400,000, and, in the last five years, over 600,000 people have died of cancer.

It is a great thing here in the Middle West for a society or an institution to be able to say it has been in existence for a hundred years, and there is a feeling of satisfaction in belonging to such an organization. In 1941 the State Medical Society of Wisconsin will celebrate the centennial of its existence. The Centennial Year will see celebrations carried on in every county not only by county medical societies but by their woman's auxiliaries. The culmination of centennial activities will be our annual state meeting of 1941.

I have appointed what I feel is an excellent centennial committee, as follows: *Dr. Robert W. Blumenthal,* Milwaukee, chairman; *Dr. Arthur Patek,* Milwaukee; *Dr. William S. Middleton,* Madison; and *Dr. P. R. Minahan,* Green Bay. A great deal of work must be done to make the celebrations the success we want them to be but I am sure there will be no lack of enthusiasm. This committee and members of the Woman's Auxiliary expect to call on many members for aid and assistance. Suggestions from the entire membership will be welcomed.

R. G. Arum

Society Proceedings

Barron—Washburn—Sawyer—Burnett

The Barron–Washburn–Sawyer–Burnett County Medical Society met on January 2 at the Land O' Lakes Hotel, Rice Lake. At a business session, Dr. Sylba Adams, Hayward, was unanimously elected to membership in the society. Dr. Harold E. Marsh, Madison, was the speaker of the evening. His topic was "Cardiac Arrhythmia."

Brown—Kewaunee—Door

Fifty members of the Brown–Kewaunee–Door County Medical Society met on January 11 at the Beaumont Hotel, Green Bay, with forty dentists from Brown and surrounding counties, to hear Dr. M. N. Federspiel, Milwaukee, discuss a subject of interest to both medical and dental groups, "Fractures and Mutilations of the Face."

Officers of the society for 1940, elected at its December meeting are:

President—Dr. L. E. Dockry, Kewaunee
President-elect—Dr. L. D. Quigley, Green Bay
Vice-president—Dr. Carl Williamson, Green Bay
Secretary–treasurer—Dr. E. J. O'Brien, Green Bay
Delegates—Dr. P. R. Minahan, Green Bay; Dr. O. A. Stiennon, Green Bay
Alternate delegates—Dr. W. W. Kelly, Green Bay; Dr. W. E. Leaper, Green Bay
Censor—Dr. J. C. Colignon, Green Bay

Chippewa

The Chippewa County Medical Society met January 23 at the Hotel Northern, Chippewa Falls. Dr. Henry A. Sincock, Superior, presented a paper on "The Practical Problems of the Physician Combining Obstetrics and Pediatric Practice," and Dr. James W. McGill, Superior, spoke on "Contraction Ring Dystocia." Members of the society also discussed the progress of the Douglas County Cooperative Medical Plan. Thirty attended the meeting.

Dane

The Dane County Medical Society met on January 9 at 8 p. m. in the Madison Club, Madison. Drs. N. A. Hill and J. W. Gale, Madison, discussed recent advances in gastroenterology and chest surgery and Dr. Francis D. Murphy, Milwaukee, spoke on "Management of Acute and Chronic Nephritis."

The society is planning to honor Dr. H. V. Bancroft, Blue Mounds, at its May meeting. Dr. Bancroft, long a member of the society, will be 80 years of age this spring.

Dodge

Representative of the bonhomie which Dr. A. G. Hough, secretary of the Dodge County Medical Society, often injects into his county medical society meeting notices is that in the notice reproduced below:

> PLEASE NOTE THE LAST PART OF THIS LETTER AND PULL THE GOOD OLD CHECK BOOK OUT OF YOUR BRITCHES POCKET!
>
> Because the speaker scheduled found out he could not come and because the meeting which was to be held at Mayville had to be changed because of scarlet fever making a second visit to Doctor Bachhuber's home, this letter comes out a little late. However, we will have a good meeting at the Lutheran Deaconess Hospital at eight o'clock Thursday evening, January 25. The speaker will be Dr. Arnold Jackson of Madison. He will speak on the subject, "Acute Abdominal Surgery".
>
> The dues for the State Medical Society are $20.00 and for the County Society $2.00. So please send in your check for $22.00.

Douglas

Voluntary sickness insurance trials in Wisconsin were discussed at the January 3 meeting of the Douglas County Medical Society at the Hotel Superior, Superior. Program speakers included: Dr. R. G. Arveson, Frederic, president of the State Medical Society; Dr. Robert W. Blumenthal, Milwaukee, and Dr. C. D. Neidhold, Appleton, of the State Society's Advisory Committee on Voluntary Sickness Insurance; and Dr. J. W. McGill, Superior, member of the Cooperative Health Insurance Committee of the Douglas county society. Twenty-eight members and five guests attended the meeting and the dinner preceding it.

Eau Claire—Dunn—Pepin

The Eau Claire–Dunn–Pepin County Medical Society met at 6:30 p. m. on January 29 at the Hotel Eau Claire in Eau Claire for dinner and a scientific program. Dr. John L. Garvey, Milwaukee, the guest speaker, discussed "Practical Considerations of the Neurological Aspects of Industrial Medicine."

Fond du Lac

Forty members of the Fond du Lac County Medical Society gathered at the Retlaw Hotel, Fond du Lac, at 6:30 p. m., January 18, for a dinner meeting. A scientific program was presented, Dr. Joseph M. King, Milwaukee, being the guest speaker. He talked on "Hand Infections."

Forest

The Forest County Medical Society met in the Laona Hospital, Laona, January 10, at 4 p. m. The relief situation in the county was discussed. Dr. Gordon E. Carroll, Laona, was elected to membership.

Jefferson

The Jefferson County Medical Society met at the Carlton Hotel, Watertown, at 6:30 p. m. on January 18. Twenty-three were present although the temperature was 24 degrees below zero. Dr. A. Miller of Watertown showed some films taken by him and discussed them. Dr. H. Mallow, Watertown, discussed "Blood Counts."

Kenosha

The Kenosha County Medical Society met on December 21 in the Kenosha Youth Foundation Building. The following Kenosha physicians were elected to serve as officers for 1940:

President—Thad W. Ashley
Vice-president—Edgar Andre
Secretary-treasurer—Harry L. Schwartz
Delegate—G. C. Schulte
Alternate delegate—W. C. Stewart
Censors—A. F. Ruffolo, C. E. Pechous, C. G. Richards

The January 18 meeting of the society was held at the Elks Club, Kenosha, at 7:30 p. m. Dr. Clarence A. Neymann, associate professor of psychiatry, Northwestern University Medical School, Chicago, was the guest speaker. He discussed "Hyperpyrexia." Twenty attended the meeting.

La Crosse

The following physicians have been elected officers of the La Crosse County Medical Society for 1940:

President—Dr. Guy F. Wakefield, West Salem
Vice-president—Dr. E. S. Carlsson, La Crosse
Secretary-treasurer—Dr. J. C. Fox, La Crosse
Censors—Dr. D. S. MacArthur, La Crosse; Dr. F. A. Douglas, La Crosse; Dr. E. H. Townsend, La Crosse
Delegate—Dr. Alf E. Gundersen, La Crosse
Alternate delegate — Dr. E. E. Gallagher, La Crosse

At its January 16 meeting in the Stoddard Hotel, La Crosse, the society had as one of its guest speakers, Dr. Cleveland J. White of Chicago, remembered by many for his excellent lectures at the State Society's postgraduate clinics last spring. Dr. White addressed the La Crosse society on "The Diagnosis and Treatment of Acne." Other speakers on the program were Mr. L. R. Wheeler and Mr. Joseph Norby of the Associated Hospital Service, Inc., Milwaukee, who discussed "Hospital Group Insurance."

The society at the same meeting passed the following resolution by a unanimous vote:

"WHEREAS, We, the members of the La Crosse County Medical Society, heartily endorse the principle of hospital insurance as applied to hospital service only,

"WHEREAS, The contemplated contract between the subscriber and the hospital includes the rendering of medical services in direct contravention to the Enabling Act as passed by the Wisconsin State Legislature authorizing hospital insurance; namely and to wit:

50% of x-ray services
50% of laboratory services
50% of electrocardiograms
50% of metabolisms

"WHEREAS, The American Medical Association and the State Medical Society have ruled that these above-mentioned services should be considered purely medical services,

"WHEREAS, We believe the inclusion of such services constitutes unsound actuarial practice being unpredictable and subject to abuse both by the profession and the laity thereby putting in peril the financial soundness of the entire hospital insurance plan,

"*Therefore, be it resolved,* That we of the La Crosse County Medical Society petition the Council of the State Medical Society to enter an injunction suit preventing the Hospital Service Corporation of Wisconsin from issuing contracts between the subscriber and the various hospitals adhering to the Wisconsin Hospital Service Corporation including any medical service whatsoever."

Langlade

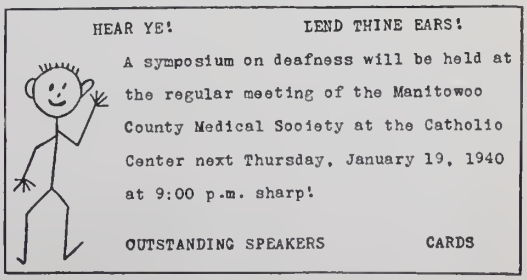
At a meeting of the Langlade County Medical Society held at the Memorial Hospital, Antigo, January 2, the following were elected officers for 1940:

President—Dr. W. P. Curran, Antigo
Vice-president—Dr. P. J. Dailey, Elcho
Secretary-treasurer—Dr. M. A. Flatley, Antigo
Delegate—Dr. W. P. Curran, Antigo
Alternate delegate—Dr. L. A. Steffen, Antigo

Following the business meeting, Dr. C. E. Zellmer, Antigo, presented a paper on "Congenital Pyloric Stenosis."

Manitowoc

Dr. Theodore Teitgen, secretary of the Manitowoc County Medical Society, announced the society's January 19 meeting as follows:



Marathon

The Marathon County Medical Society met on December 21 at the Hotel Wausau in Wausau. Dr. W. S. Middleton, Madison, was the guest speaker and discussed "Specific Treatment of Pneumococcus Pneumonia." Thirty members attended the meeting. Dr. Ernest Newman, Wausau, director of the Marathon County Health Unit, and Dr. Donald M. Green, Wausau, were elected to membership in the society.

Milwaukee

The Medical Society of Milwaukee County held its January 12 meeting in the Milwaukee Athletic Club. A resolution was adopted embodying several changes in the society's by-laws having to do with membership and discipline. Dr. John L. Garvey, Milwaukee, in a program feature entitled, "Fifteen Minutes of Preventive Medicine," discussed "Spinal Fluid Examinations and Interpretations." Dr. Loyal Davis, Chicago surgeon, spoke on "Neurological Surgery."

The society held its third annual gridiron banquet on January 18 at the Wisconsin Club, Milwaukee. In describing the program, the *Milwaukee Sentinel* reported "the scalpels of wit performed a major dissection on two of the most booted about medical subjects in recent history—allergies and urinalysis for drunken driving." "The skits," the *Sentinel* continued, "came after a banquet and cigars, the smoke of which was wafted away by community singing. Pictures, formal and informal, of a great number of the society membership were displayed via lantern slide." Dr. L. J. Van Hecke, Wauwatosa, was chairman of the event.

Oneida—Vilas

The Oneida–Vilas County Medical Society held a dinner-meeting at the Oneida Hotel, Rhinelander, on January 18. At 4:30 p. m. Dr. W. S. Middleton, Madison, presented an illustrated lecture on "Cardiac Arrhythmias; Their Detection and Management." Dinner was served at 6 p. m. and then a round table discussion was lead by Dr. Middleton on "Some Experiences in Therapeutics."

Outagamie

Officers of the Outagamie County Medical Society for 1940 have been announced as follows:

President—Dr. W. E. Archer, Appleton
Vice-president—Dr. R. T. McCarty, Appleton
Secretary-treasurer—Dr. George L. Boyd, Kaukauna

At its meeting on January 18 at the Conway Hotel, Appleton, the society had as its guest speaker Dr. F. W. Madison, Milwaukee. Dr. Madison discussed "The Anemias."

Polk

Members of the Polk County Medical Society were the guests on January 18 of Drs. V. C. Kremser, Amery, and T. W. Dasler, Deer Park, at the Indian Head Lodge, Balsam Lake. Dinner was served at 7 p. m. and then a symposium on gallbladder disease was presented, discussion leaders being Drs. M. Comfort and Howard K. Gray of the Mayo Clinic, Rochester, Minn. Dr. Comfort discussed the subject from the medical angle and Dr. Gray from the surgical.

Portage

The Portage County Medical Society elected the following officers for 1940 at its meeting in Stevens Point, January 10:

President—Dr. F. R. Krembs, Stevens Point
Vice-president—Dr. H. P. Benn, Stevens Point
Secretary-treasurer—Dr. T. L. Harrington, Stevens Point
Delegate—Dr. A. G. Dunn, Stevens Point
Alternate delegate—Dr. Maurice Rice, Stevens Point
Censor—Dr. Wayne F. Cowan, Stevens Point

Announcement was made of the election of Dr. W. W. Gregory, Stevens Point, to life membership in the Portage county society and the State Medical Society of Wisconsin.

Racine

The Racine County Medical Society held its January 18 meeting at the Meadowbrook Country Club, Racine, at 6:30 p. m. Dinner was served and the relief situation in Racine county discussed by supervisors of relief and pensions and members of the society. Thirty-one members and eight guests attended.

Rock

Following is a note from the minutes of the Rock County Medical Society's December meeting regarding two actions taken at that time:

"It was moved that the Society protest the inclusion under hospital insurance of any medical service such as x-ray, anesthesia, etc.

"It was moved that the Rock County Medical Society protest the setting up of a schedule of fees by the insurance companies without consulting with the Society. A committee was requested to make a formal protest on present fee schedules as established by them without consulting the Society."

The January meeting of the Rock County Medical Society was held at the Monterey Hotel in Janesville on January 23. Dr. L. G. Gatewood, clinical professor of medicine at Rush Medical College, Chicago, delivered an address on "Medical Management of Peptic Ulcers."

Sauk

At a dinner meeting in the Warren Hotel, Baraboo, December 20, the Sauk County Medical Society elected the following officers for 1940:

President—Dr. H. J. Irwin, Baraboo
Vice-president—Dr. J. F. Moon, Baraboo
Secretary-treasurer—Dr. C. B. Pope, Baraboo
Delegate—Dr. A. C. Edwards, Baraboo.
Alternate delegate—Dr. M. F. Huth, Baraboo

The guest speaker on the scientific program was Dr. W. J. Bleckwenn of Madison.

Shawano

The Shawano County Medical Society met on January 19. Dr. O. E. Damp, Birnamwood, was admitted to membership in the society. Officers for 1940 were elected as follows:

President—Dr. A. A. Cantwell, Shawano
Vice-president—Dr. F. L. Litzen, Gresham
Secretary-treasurer—Dr. E. E. Evenson, Wittenberg
Censor (three year term)—Dr. V. Rogers, Bowler
Delegate—Dr. A. A. Cantwell, Shawano
Alternate delegate—Dr. F. L. Litzen, Gresham

Washington—Ozaukee

A brief commentary on the recent cold and heavy snow throughout Wisconsin is the January report of Dr. C. H. Kalb, Grafton, secretary of the Washington–Ozaukee County Medical Society. Dr. Kalb says: "Due to inclement weather no meeting was held."

Walworth

The Walworth County Medical Society has elected the following physicians as officers for 1940:

President—E. D. Hudson, Lake Geneva
Vice-president—H. J. Kenney, Delavan
Secretary—T. J. Kroyer, Walworth

Winnebago

The Winnebago County Medical Society met at the Athearn Hotel, Oshkosh, at 6:30 p. m. on January 4. A round table discussion on appendicitis was led by Dr. F. Gregory Connell, Oshkosh. Dr. Ralph P. Sproule, Milwaukee, president-elect of the State Medical Society, was the guest of the evening.

Ninth Councilor District

The Ninth Councilor District Medical Society met on January 25 in Wisconsin Rapids. Dinner was served at 6 p. m. at the Hotel Witter, after which the following program was given: "External Eye Diseases," Dr. Lyman A. Copps, Marshfield; "Pericarditis," Dr. A. L. Millard, Marshfield; "Recent Advances in Hematology," Dr. Ovid O. Meyer, Madison.

Milwaukee Academy of Medicine

Dr. Eben J. Carey, dean of the Marquette university medical school, was installed as president of the Milwaukee Academy of Medicine at the Academy's annual dinner at the University club, Milwaukee, January 16. He succeeds Dr. John L. Garvey. Dr. N. Warren Bourne was elected president-elect to take office a year hence.

Other officers chosen were: vice-president, Dr. Edward Henes, Jr.; secretary, Dr. Theodore L. Squier; treasurer, Dr. Fred W. Madison; librarian, Dr. Walter P. Blount.

Dr. G. V. I. Brown and Dr. Charles H. Stoddard were given honorary memberships.

Addressing the academy, Harlan B. Rogers, Portage, president of the State Bar association, said that the misunderstanding by the public of the medical and legal professions is due to failure of both groups to keep the public informed of progress in simplifying their professional services.

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society met with the Milwaukee Psychological Club at the University Club in Milwaukee on January 25. Dinner was served at 6:30 p. m. and at 8 p. m. a scientific program was presented. Dr. Mandel Sherman of the department of education of the University of Chicago was the guest speaker. His subject was "Newer Psychiatric and Psychologic Bases of Juvenile Schizophrenia."

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society enjoyed a "triple feature" motion picture program at its meeting at the University Club on January 9, pictures shown being "Photographic Study of the Larynx," "High Speed Pictures of the Vocal Cord," and "Evisceration of Globe with Scleral Implant and Preservation of Cornea."

Officers for the coming year were elected at this meeting as follows:

President—Dr. John B. Hitz
Vice-president—Dr. John W. Truitt
Secretary-treasurer—Dr. Ralph T. Rank
Board of Directors—Drs. Herbert B. Schmidt, Edwin C. Bach, Henry Beeson, and the president, vice-president, and secretary-treasurer above named.

The society is planning a joint meeting with the Central Wisconsin Society of Ophthalmology and Otolaryngology on February 12 in Milwaukee.

Milwaukee Society of Clinical Surgery

On January 30 at the University Club, Milwaukee, the Milwaukee Society of Clinical Surgery held its annual dinner meeting. On the scientific program the following addresses were given: "Short-Wave in Surgery," by Dr. Karl Schlaepfer, Milwaukee; "The Mechanics of Fracture," by Dr. L. D. Smith, Milwaukee; "Treatment of Burns," by Dr. Stanley J. Seeger, Milwaukee.

News Items and Personals

Dr. James C. Sargent, Milwaukee, has been listed in the central committee of the National Physicians' Committee for the Extension of Medical Service, a group organized voluntarily in Chicago, November 18, 1939, to carry on education of the public regarding extension of medical service and preventive medicine. Several of the physicians heading the group are widely known for their work in the American Medical Association, but the organization is not officially connected with the American Medical Association. Dr. Edward H. Cary, Dallas, Texas, is president of the committee; Dr. Austin A. Hayden, Chicago, is secretary; and Dr. N. S. Davis III, Chicago, is treasurer. Some 800 physicians, representing all states in the United States, will constitute the central committee of the organization.

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On January 12 the new Mondovi Clinic-Hospital was opened to the public. The two-story building is of brick and tile construction and has two wings—each six by thirty-three feet. Heading the medical staff is *Dr. Darrell S. Sharp*, 1929 graduate of the University of Wisconsin Medical School, who has practiced in Mondovi since 1930. His associate is *Dr. Frank Gillette*, 1930 graduate of Harvard Medical School, and, until recently, a medical officer in the United States Navy.

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Dr. John P. Koehler, Milwaukee health commissioner, in his annual report on the Milwaukee Health Department, announced an improvement over all previous health records and the establishment of several that probably never will be equalled. His report cites only one case of diphtheria; a reduction in infant and maternal mortality; only three cases of typhoid fever, none of which resulted in death; and decreases in pneumonia and pulmonary tuberculosis.

Dr. Koehler commended the Medical Society of Milwaukee County for its cooperation with the health department in conducting immunization campaigns, evening syphilis clinics and a syphilis detection program, and credited that society's premature infant and feeding bureau with material assistance in lowering the infant death rate. He asserted, "This cooperative program between the county government, Visiting Nurse Association, and the private medical profession is a shining example of what can be done through united effort."

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The Milwaukee Times, January, 1940, states that three Milwaukee physicians were recently elected to fellowship in the International College of Surgeons. They are *Drs. L. D. Smith, R. W. Roethke* and *Karl Schlaepfer*.

The Council on Scientific Work of the State Medical Society met in Madison on January 10. Those attending the meeting were *Dr. J. A. Evans*, La Crosse; *Dr. G. W. Krahn*, Oconto Falls; *Dr. C. J. Smiles*, Ashland; *Dr. W. S. Middleton*, Madison; *Dr. E. S. Schmidt*, Madison; and Mr. George B. Larson, assistant secretary of the Society.

The council elected as its chairman, Dr. Eben J. Carey, Milwaukee, who has served on the council since its inception. The members discussed the spring clinics to be held April 24–26 in La Crosse, Watertown and Wausau, and the annual meeting program to be presented in September.

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Dr. H. A. Sincock, Superior, spoke on "Importance of Health in the Life of the Well Balanced Child," at a meeting of the parent–teacher association of Billings School, Superior, January 18.

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Stockholders of the Marshfield Clinic, Marshfield, reelected *Dr. R. P. Potter* president of the clinic on January 9. *Dr. W. G. Sexton* and *Dr. L. A. Copps* were reelected vice-president and secretary respectively, and *Dr. F. A. Boeckman* was elected treasurer to succeed *Dr. William Hipke*.

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Dr. Maynard H. Fuller, Green Bay, was recently reappointed examiner for the blind of Brown county.

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Dr. Stanley J. Seeger and *Dr. Arthur A. Schaefer* have formed a partnership for the practice of surgery with offices at 324 East Wisconsin Avenue, Milwaukee.

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The University of Wisconsin Medical Society, Madison, had as its guest speaker, January 12, Dr. John A. Bigler, medical director of the outpatient department of Children's Memorial Hospital, Chicago. Dr. Bigler discussed "Scarlet Fever, the Dick Test and Hemolytic Streptococcus Throat Cultures."

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The newly formed Wisconsin Tuberculosis Society held its first meeting January 24 at Lake View Sanatorium, Madison. Fifty-five physicians interested in the treatment of tuberculosis came from various parts of the State to participate in the event. *Dr. W. H. Oatway, Jr.*, Madison, was elected president of the group and *Dr. A. A. Pleyte*, Milwaukee, was elected secretary–treasurer.

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Mr. J. G. Crownhart, secretary of the State Medical Society, Madison, underwent an emergency operation at the Madison General Hospital on

January 9 for strangulated hernia acquired in the office the previous day. He is making favorable progress and expects to reassume his duties at Society headquarters shortly.

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The Bloomer Advance, Bloomer, Wisconsin, newspaper announced on January 18: "The best attendance of members of the local Kiwanis Club in the history of the Bloomer club was noted at the meeting at Hovland's Cafe last evening . . . The main talk of the evening was by Dr. (F. E.) Butler of Menomonie, whose subject was 'socialized medicine.' "

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Dr. A. H. Heidner, West Bend, described the problems of the general practitioner and the small hospital at the midwinter conference of the Wisconsin Hospital Association at the Schroeder Hotel, Milwaukee, January 11; *Dr. S. J. Seeger*, Milwaukee, discussed the problems in large hospitals.

At this meeting Mr. Nels E. Hanshus of Eau Claire was reelected president of the Wisconsin Hospital Association and Dr. E. T. Thompson, Milwaukee, was elected executive secretary.

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Dr. Addie M. Schwittay of the department of pediatrics and obstetrics, Jackson Clinic, Madison, presented, February 6, one of a series of lectures on health being sponsored by the Madison Y. W. C. A. She discussed "Physiology and Hygiene of the Reproductive System."

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The "Dr. George W. Jenkins Memorial Fund" of $11,237 has been set up by the University of Wisconsin board of regents in accordance with the terms of the doctor's will which stipulated that, after the death of his wife and daughter, the residue of his estate be kept intact and the income used for the maintenance and support of the medical school. Dr. Jenkins, who was graduated by the Medical Department of Columbia College, New York, in 1851, practiced in Milwaukee, Delton, and Wisconsin Dells — also called Kilbourn — for many years. He died at the age of 89 years in 1913. His widow died in 1918 and the daughter in 1939.

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Dr. Allen Filek, district health officer located in Green Bay, addressed the Lincoln parent-teacher association of Green Bay on January 18, his subject being "The What, When, Why and How of Protective Measures."

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Dr. F. R. Janney, Wauwatosa pediatrician, discussed the question "How Shall We Counsel Our Children?" before a meeting of the Federation of Women's Clubs in Manitowoc, January 8.

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Dr. James Garland, Milwaukee, gave a talk on cancer control before the Oshkosh Council of Catholic Women, Oshkosh, on January 8.

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On President Roosevelt's fifty-eighth birthday, January 30, many Wisconsin physicians assisted state and local groups in staging birthday balls and other celebrations to collect funds for the *National Foundation for Infantile Paralysis*. The foundation, founded January 3, 1938, has as its president Mr. Basil O'Connor, New York lawyer and former partner of President Roosevelt; it is managed by a board of trustees and its scientific and educational activities are in charge of physicians and educators of distinction, according to the January 13 issue of the Journal of the American Medical Association. The same issue of that journal praises the foundation for efficiency and economy in financial and scientific management.

In 1938 the foundation collected $1,010,378.14. In 1939 one-half of the net proceeds from the birthday celebrations, after the expenses of the national campaign were deducted, went to the foundation; this amount was $600,000. The remaining 50 per cent was left in communities throughout the United States for local relief and to this latter amount was added $50,000 as a contribution from the Will Rogers Memorial Commission.

CHIROPRACTOR BUYS THE SPA

The Spa, historic Waukesha health institution, has been sold to an East Troy, Wisconsin, chiropractor and his associate. It will be converted into a chiropractic clinic.

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Van Meter Prize Award

The American Association for the Study of Goiter is again offering the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held at Rochester, Minnesota, on April 15, 16 and 17, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; they should not exceed 3000 words in length, must be presented in English and a typewritten double-spaced copy sent to the corresponding secretary, Dr. W. Blair Mosser, 133 Biddle Street, Kane Pa., not later than March 15.

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Included on the staff of the recently enlarged *Lakeside Laboratories*, Milwaukee, are the following: Mr. Fred Padden, chemical engineer and plant superintendent, first employee of the Laboratory; Dr. C. O. Miller, technical director, formerly of Northwestern University; Dr. C. H. Mellish, in charge of physiological and pharmacological control, formerly of the University of Wisconsin; Dr. A. J. Baer, medical adviser, formerly of the University of Berlin, Germany; and Dr. Ernst Geiger, formerly of the University of Pec, Hungary.

OFFICIAL NOTICE OF PROPOSED CHANGE IN CONSTITUTION

The following proposed amendment to Section 2, Article IX of the Constitution of the State Medical Society of Wisconsin—submitted at the 1939 session of the House of Delegates of the State Society by the Jefferson County Medical Society through Dr. W. S. Waite of Watertown, delegate—will be voted on by the House at its September 1940 session in Milwaukee.

Amendment Relative to Elections

Section 2. The President, President Elect, Speaker and Vice-Speaker shall be elected by the House of Delegates. The Secretary and Treasurer shall be elected by the Council. Councilors shall be elected at a meeting of their respective district societies held within the twelve months' period prior to the annual meeting of the State Society at which the term of Councilor expires. Certification of such election, signed by the President and Secretary of the councilor district society, shall be placed in the hands of the Secretary of the State Medical Society prior to the annual meeting of the Society in the year in which the term of such Councilor expires. In the event a councilor district fails so to certify its election, the election for Councilor of such district shall be by the House of Delegates. Notices of election of a Councilor in a district shall be incorporated in a mailed notice to the members of the district at least seven days before the meeting at which the election is to be held.

Election, where more than one nomination is received, shall be by ballot and a majority of votes cast shall be necessary to elect. Each candidate for Councilor must be a resident of the district which it is proposed to represent and no person known to have solicited votes for or sought the office of Councilor shall be eligible for the current election. Other procedure essential to the election shall be governed by Robert's Rules of Order.

The officers, except the Councilors, shall be elected annually. The terms of Councilors shall be for three years, and all officers shall serve until their successors are elected and installed. There shall be elected one Councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional Councilor for each additional 250 members or major fraction thereof. As nearly as possible, one-third of the members of the Council shall be elected each year.

The President-Elect shall automatically succeed to the office of President at the conclusion of his one-year term of President-Elect.

BIRTHS

A daughter, Carol Jean, to Dr. and Mrs. H. G. E. Mallow, Watertown, on January 5.

A son to Dr. and Mrs. J. V. Herzog, Milwaukee on January 5.

A son to Dr. and Mrs. Ovid O. Meyer, Madison, on January 2.

A daughter, Ellen Louise, to Dr. and Mrs. M. E. Monroe, Hartford, on November 4.

MARRIAGES

Dr. M. H. Wirig, Madison, to Miss Eleanor Narloch, Antigo, on January 13.

Dr. Paul Goodman, Milwaukee, to Miss Margaret Helen Lewis, Milwaukee, on January 13.

Dr. O. R. McMurry, Eagle River, to Mrs. Marie Isbell, Eagle River, on January 8.

DEATHS

An outline of the life and work of *Dr. William Snow Miller*, Madison, who died on December 26, 1939, appears on pages 109–110, 145 of this issue of THE JOURNAL.

Dr. John Welton Fisher, Milwaukee, died November 25 in Detroit, Michigan. He was 91 years of age. Dr. Fisher received his medical degree from Rush Medical College, Chicago, in 1877. For more than fifty years he was a medical director of the Northwestern Mutual Life Insurance Company. Surviving him are a son and a daughter.

Dr. Charles R. Farnharm, Milwaukee, died of a heart attack in Milwaukee on December 8. He was 60 years of age. He was graduated in medicine from the Milwaukee Medical College in 1904. He took postgraduate work in ear, eye, nose and throat diseases in Chicago and New York and specialized in the treatment of those diseases. The doctor, a native of Delavan, Wisconsin, was a captain in the United States medical corps during the World War and saw a year and a half of service overseas.

Dr. Don R. Flower, Park Falls, died November 14 at his farm home. He was 88 years of age and had practiced in Park Falls for almost thirty years. The doctor was a native of Ohio and an 1894 graduate of the Bennett College of Eclectic Medicine and Surgery, Chicago. For many years he was a member of the Park Falls city council and also served that city as health officer. He is survived by two sons.

Dr. Frederick Storchheim, Wauwatosa, died December 8. He was forty-eight years of age.

A native of Vienna, Austria, Dr. Storchheim came to the United States in 1909. After studying chemistry in Brooklyn and Chicago, he entered Rush Medical College, Chicago, being graduated by that institution in 1929. He joined the staff of the Milwaukee Asylum for the Chronic Insane in 1931, after a period of medical service at St. Elizabeth's Hospital, Washington, D. C.

Dr. Storchheim was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association. He was a member of the American Psychiatric Association.

Surviving Dr. Storchheim are his widow and a son eight years of age.

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Dr. Charles N. Dawson, Black Earth, died of cirrhosis of the liver, December 26, in Beloit, where he had gone to spend the holidays with relatives. He was 41 years of age.

Dr. Dawson was born in Beloit and received his early education there. In 1917 he enlisted in the United States Navy and throughout the duration of the World War he served in the hospital corps, making fourteen trips across the Atlantic and being ranked as a first class pharmacist's mate at the close of the war. He was graduated in medicine from Washington University School of Medicine, St. Louis, in 1925. Before locating in Black Earth, he practiced medicine in Palmyra, Wisconsin, and in Beloit.

Dr. Dawson was a member of the Dane County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by one daughter.

Dr. William Heitman, Nashotah, died of a heart attack, December 17. The doctor, who was 64 years of age at the time of his death, retired from practice in 1933 because of a heart ailment. He was born in Milwaukee and was graduated from the Milwaukee Medical College in 1902. Dr. Heitman practiced his profession for thirty years in Milwaukee. He is survived by his widow.

Dr. Victor Kutchin, Green Lake, died November 22 at his home. He was 88 years old.

Before taking up the study of medicine, Dr. Kutchin entered the ministry and in 1880 was appointed chaplain of the state prison of Waupun. Several years later he obtained a leave of absence from this position to attend Rush Medical College, Chicago, from which he was graduated in 1896. He then returned to Waupun to serve as both prison chaplain and physician. Several years ago he located in Green Lake where he had spent part of his earlier life.

Dr. Kutchin, an ardent ornithologist and naturalist, wrote a book on birds, which received much favorable comment in the press, and a group of poems entitled "Leaves." He also wrote two novels. He was a member of the Wisconsin Historical Society.

Dr. H. A. Sharpe, Verona, died suddenly at his home on January 20 of a heart attack. The day before he had walked a mile through snowdrifts in search of aid after he had expended considerable effort trying to extricate his car which became stalled in the snow while he was calling on patients in the rural area surrounding Verona.

The doctor was 57 years of age and in December, 1939, observed the twenty-third anniversary of his practice in Verona. One of his hobbies was the raising of Cheviot sheep.

He was a 1907 graduate of Northwestern University Medical School, a member of the Dane County Medical Society and a member of the State Medical Society of Wisconsin. He was a Fellow of the American Medical Association. Surviving him are his widow, a daughter and a son—Dr. Donald Sharpe of Dubuque, Iowa.

Dr. Sara G. Vernon, one of Madison's pioneer women physicians, died on January 7 in a Madison hospital following a long illness. She was 75 years of age and had practiced in Madison for about thirty years. Her specialty was obstetrics. She was graduated from the Northwestern University Woman's Medical School, Chicago, in 1897 and received her license to practice medicine in Wisconsin in 1898.

Dr. Peter A. Schulberg, Durand, died in a Montana hospital December 29, 1939, after an illness suffered following an influenza epidemic in Durand about a year ago.

The doctor was 49 years of age. He was graduated from the University of Illinois College of Medicine in 1914 and practiced his profession in Maiden Rock and Montevideo, Minnesota, before locating in Durand where he specialized in surgery. He was forced to retire from practice in Durand last year, after eighteen years in practice there, because of illness.

Dr. Schulberg was a member of the Eau Claire–Dunn–Pepin County Medical Society and the State Medical Society of Wisconsin. He was a Fellow of the American Medical Association.

SOCIETY RECORDS

New Members

E. M. Dessloch, Prairie du Chien.

J. M. Grinde, Waunakee.

Winifred Ingersoll, 119 East Washington Avenue, Madison.

S. L. Chojnacki, 928 Milwaukee Avenue, South Milwaukee.

J. O'D. McCabe, 208 East Wisconsin Avenue, Milwaukee.

G. W. Petersen, Neenah.

W. O. Hendrickson, Pittsville.

P. E. Aszman, 3428 West Burleigh Street, Milwaukee.

A. J. Verdone, 747 North Twenty-seventh Street, Milwaukee.

Changes in Address

W. J. Urben, Cuyahoga Falls, Ohio, to Southern Colony, Union Grove.

R. R. Rath, Lakeland, Florida, to Granton.

R. C. Morrison, Madison, to Winnebago State Hospital, Winnebago.

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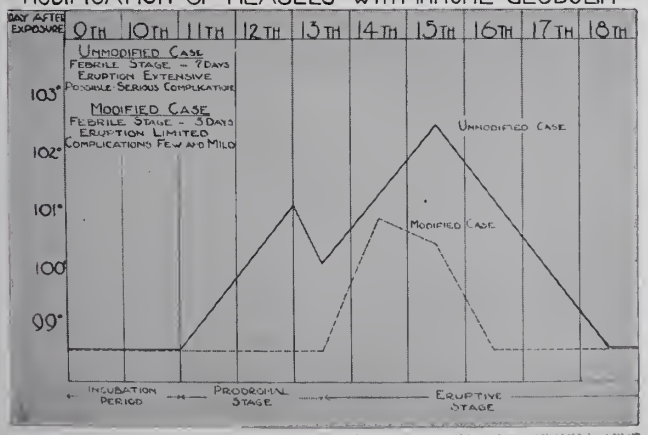

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. Frank W. Pope, Racine, President
Mrs. Donne F. Gosin, Green Bay, President-Elect
Mrs. Thad W. Ashley, Kenosha, Vice President
Mrs. Homer M. Carter, Madison, Recording Secretary
Mrs. Charles E. Constantine, Racine, Corresponding Secretary
Mrs. Edwin P. Bickler, Milwaukee, Treasurer
Mrs. William M. Jermain, Milwaukee, Parliamentarian

COMMITTEE CHAIRMEN

Archives—
Mrs. Cornelius A. Harper, Madison
Convention—
Mrs. Eben J. Carey, Milwaukee
Finance—
Mrs. Arthur J. McCarey, Green Bay
Hygeia—
Mrs. Irenaeus N. Tucker, Racine
Organization—
Mrs. Ernest S. Schmidt, Green Bay
Philanthropic—
Mrs. Edgar F. Andre, Kenosha
Press and Publicity—
Mrs. Arnold S. Jackson, Madison
Program—
Mrs. James C. Hassall, Oconomowoc
Public Relations—
Mrs. Ira F. Thompson, Racine
National Exhibit (Special Committee)—
Mrs. E. Lee Lochen, Waukesha

Public Relations

By MRS. IRA F. THOMPSON
Racine

OUR auxiliary faces another year of work, and both national and state officers feel that much of that work must be in public relations.

We all probably realize that never has modern medicine been confronted by such a crisis as today's. No group has given more unselfishly than the medical profession in time, money—even life—to advance the health and welfare of the people.

We realize that change is inevitable, but we want the change planned and carried out by the medical profession and not by politicians.

It seems to me that now is the time for all good wives to come to the aid of the profession. Laissez faire is out. Were I writing politically, I should tell you to ask your husband just how safe he considers the basic science law, for instance, in this State, and *why*. And then I should tell you that, after all, we wives are citizens and voters in a democracy, and should be active as such—especially regarding health matters.

Let's not be ostriches. The problem is here now—and the fight is on. We must act now or never. We're late getting started, but let's do all we can now. I might include the words Marshall Foch wired back to Paris during the battle of the Marne, quoted by Dr. Arveson in his presidential address last fall, "My right is broken, my left is retiring, my center is weakening, but the situation is well in hand. *We are attacking.*"

Our job, as an auxiliary, is to promote health education, and act as liaison officers between the profession and the public. We all belong to woman's clubs, and when they rise, impelled by propaganda and sentiment, to approve the Wagner Health Bill, for example, we must rise too, and *know* and *say* why approval should be withheld at this stage, at least.

These discussions may come up at bridge clubs. Are we informed so as to say the right thing? Read the report of the Committee on the Wagner Health Bill in the J. A. M. A. for June 3, 1939, memorize it—understand it.

We must get rid of the idea that "Public Relations" means one big open meeting a year, with a speaker, to which by every means short of shanghaiing, we procure the attendance of our membership, our husbands and our friends. After all, most of that audience do not need to be sold on legitimate medicine. They have a part in it.

Instead of such a futile gesture as that has proved to be, let us sponsor at least one tea (with a good speaker) for the presidents of every lay woman's organization in the county which has a program. Let us, through our regional and county public relations chairmen, urge upon these women to

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have at least one program during the year in which health matters are stressed, and offer to get them a qualified speaker for such meetings.

P. T. A.s always have a fair attendance. Many groups may be reached through the presidents of these organizations.

Some auxiliaries are fortunate enough to be connected with a county medical society which has a speaker's bureau. Let's keep at it, until we all have. After all, how could our local doctors be placed before the public to better advantage? But be sure your doctor has a message, and can present it.

Mr. Crownhart of the State Society will gladly advise or assist us in any way he can. Quantities of material on health education, answers to questions and advice may be had by writing Dr. W. W. Bauer, at the American Medical Association, 535 N. Dearborn Street, Chicago. For material on medical economics, write Dr. R. G. Leland, Department of Medical Economics, same address.

On Thursdays, 4:30 p. m., E.S.T., over the Blue Network, the American Medical Association is presenting "Timely Topics from Medical News of the Week." This will continue for thirty weeks, from November 2, 1939, and will include entertainment. Our own membership would do well to tune in—for the world "sure do move" and we must keep up.

Beside a large number of speakers, the State Board of Health has some excellent films on child care and will send a qualified speaker to present them. A long list of available speakers is also available from the Auxiliary program chairman.

The Wisconsin Anti-Tuberculosis Association, 1018 N. Jefferson Street, Milwaukee, has speakers, and at least two splendid films. If these have not appeared before your groups, they should. These services are gratis, but it should be remembered these speakers are busy people, and should have a good-sized audience.

One more thing. County public relations chairmen should remember that their jobs last until successors are installed, not just until the annual picnic. So, if a lay organization has filled its program for this year, book a medical speaker for *next* year!

State Auxiliary Board Meeting Report

By MRS. HOMER M. CARTER
Madison

THE annual board meeting of the Auxiliary to the State Medical Society of Wisconsin was held in Milwaukee, January 18, 1940, at the Milwaukee Y.W.C.A. Twenty-nine state and county officers were present.

The first report was read by the Auxiliary's president, Mrs. Frank W. Pope, Racine, who mentioned the writing of 200 letters and visits to two county organizations. She spoke of the difficulty of obtaining lists of local standing committees and urged greater cooperation in that respect. She reported that the Grant county auxiliary had been disbanded. She said a long list of speakers was available for county auxiliary programs and open meetings. And she closed with an expression of hope that each county organization would affiliate more closely with the State Auxiliary. Reports were then given by the State Auxiliary treasurer, Mrs. Edwin P. Bickler, Milwaukee, and the corresponding secretary, Mrs. Charles E. Constantine, Racine.

Committee Chairmen Report

The chairman of the committee on archives, Mrs. C. A. Harper, Madison, urged the collecting of interesting facts and valuable relics of pioneer doctors.

Convention chairman, Mrs. Eben J. Carey, Milwaukee, announced the appointment of Mrs. H. J. Heeb and Mrs. Charles Fidler of Milwaukee as co-chairmen for the state convention in September, 1940. Mrs. Carey urged that each county stress a larger attendance at the state convention and that names of delegates be sent to Mrs. Pope as early as possible.

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[1-7] Bibliography on request

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Mrs. Arthur J. McCarey, Green Bay, chairman of the committee on finance, discussed the Auxiliary income, made up of membership dues and $100 from the State Medical Society, and the budget.

Mrs. I. N. Tucker, Racine, Hygeia chairman, gave a very complete report, telling how she and her committee had been successful in interesting the National Association of Cosmeticians in subscribing to Hygeia. She also distributed sample copies of the magazine to all present.

Mrs. Ernest S. Schmidt, Green Bay, chairman of the committee on organization, presented plans for expansion during the coming year. She stated several contacts have been made with those in counties where auxiliaries do not now exist, but no new county organizations have been started as yet.

Chairman of the committee on press and publicity, Mrs. Arnold S. Jackson, Madison, announced that the program for the Wisconsin Medical Journal is succeeding very well because of the excellent cooperation of state officers and county chairman in getting articles and reports to her.

Mrs. James Hassall, Oconomowoc, program chairman, reported that, after conferring with members of the State Medical Society and the program chairman of the national auxiliary, she had sent a letter to each county program chairman on types of programs which might be advantageously presented.

Mrs. I. F. Thompson presented her report on public relations in a very entertaining manner, naming the national health project "political medicine" rather than "socialized medicine." She feels that each auxiliary member should make a personal effort to study the Wagner Health Bill. She suggested inviting leaders of community organizations to hear good speakers on "political medicine," and stressed the value of medical speakers in lay organizations.

Mrs. Edgar F. Andre, Kenosha, who is organizing the Auxiliary philanthropic committee, reported on progress being made in this regard in various counties. Mrs. Andre requested that county chairmen inform her of philanthropic projects being tried in their respective counties.

Mrs. E. Lee Lochen, Waukesha, who has charge of the national exhibits, asked that each county appoint a chairman of exhibits and send in exhibits for both the national and state auxiliary meetings.

It was then moved by Mrs. E. Lee Lochen that the committee reports be accepted as a whole; the motion was seconded by Mrs. Donne Gosin, Green Bay, and carried.

Mrs. Pope announced that, due to lack of a quorum, a special meeting of the nominating committee would be called later. Mrs. Gosin, president-elect of the Auxiliary, gave a word of greeting and the following county presidents gave informal reports on activities in their auxiliaries: Mrs. M. H. Fuller, Green Bay; Mrs. L. V. McNamara, Montello; Mrs. Henry E. Twohig, Fond du Lac; Mrs. H. L. Schwartz, Kenosha; Mrs. C. D. Partridge, Milwaukee; Mrs. A. S. Pfeiffer, Racine; Mrs. E. D. Sorenson, Elkhorn; Mrs. A. H. Barr, Port Washington; and Mrs. R. H. Bitter, Oshkosh.

Mrs. Pope reminded those present to read carefully the letter from Mr. J. G. Crownhart, secretary of the State Society, mailed November 2, 1939, containing a discussion of the Wagner Health Bill by Dr. Irvin Abell, Louisville, Ky., immediate past president of the American Medical Association.

Columbia—Marquette—Adams

The December meeting of the Woman's Auxiliary to the Columbia-Marquette-Adams County Medical Society was held at St. Mary's Hospital, Columbus. Dinner was enjoyed with members of the medical society and then a business meeting was held. The following were named officers for 1940:

President—Mrs. L. V. McNamara, Montello
President-elect—Mrs. C. J. Radl, Wisconsin Dells
Secretary—Mrs. John Houghton, Wisconsin Dells
Treasurer—Mrs. H. E. Gillette, Pardeeville

Dane

On December 13 the Woman's Auxiliary to the Dane County Medical Society met at the home of Mrs. Homer M. Carter in Madison. At 1 p. m. luncheon was served, assisting hostesses being Mrs. H. L. Greene, Mrs. William A. Werrell, Mrs. Stanley J. Briggs, Mrs. H. E. Marsh and Mrs. N. A.

Hill. Following the luncheon Mr. Alfred Ingersoll spoke interestingly on his experiences with youth hostel groups in Germany, France, Belgium and Holland, and Mrs. H. N. Winn sang two beautiful Christmas songs—"Cantique de Noel" and "No Candle Was There and No Flame." Mrs. Winn was accompanied at the piano by Mrs. Carter. After a short business meeting, Mrs. H. E. Marsh gave a brief resume of the food and drug act.

Douglas

Concluding their activities for the year 1939, members of the auxiliary to the Douglas County Medical Society met in the Androy Hotel, Superior, recently for a 1 p. m. luncheon and to elect a new slate of officers for 1940.

Mrs. E. A. Myers, who was named president-elect at the annual meeting last year, advanced to the position of president while Mrs. J. M. Meyers was named to the president's post to take office in 1941.

Others named were Mrs. J. W. McGill, vice-president and Mrs. J. C. Kyllo, secretary-treasurer.

Standing committees were also elected. Mrs. G. J. Hathaway was named to arrange the year's program and Mrs. E. L. Campbell is to have charge of public relations.

Kenosha

The Kenosha County Medical Society held an evening meeting on January 2 at the home of Mrs. Harry Schwartz, Kenosha. Assisting Mrs. Schwartz were Mmes. Edgar Andre, C. M. Creswell, L. H. Lokvam and P. E. Pifer. "The Rediscovery of Man," by Henry C. Link was reviewed by Mrs. D. T. John and at the close of the program refreshments were served buffet style from a table made festive with Christmas decorations.

Manitowoc

The auxiliary to the Manitowoc County Medical society held its Christmas party on December 22 at the home of Mrs. Arthur Bussey in Two Rivers. Mrs. Bussey, Mrs. W. E. Donohue and Mrs. Nelson A. Bonner were hostesses.

The program of games was under direction of Mrs. A. F. Stueck, and honors were won by Mrs. F. E. Turgasen and Mrs. C. E. Wall.

Mrs. A. W. Kozelka of Two Rivers was introduced as a new member.

Tea was served after the program to the thirteen attendants.

Milwaukee

An evening reception with refreshments was held February 12 at the Astor Hotel Roof Garden, Milwaukee, to introduce the new officers of the Woman's Auxiliary to the Medical Society of Milwaukee County to the auxiliary membership. Eighty-five members welcomed the following 1940 officers:

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President—Mrs. C. D. Partridge, Cudahy
President-elect—Mrs. R. D. Champney, Milwaukee
Vice-president—Mrs. R. D. Bergen, Milwaukee
Corresponding secretary—Mrs. W. H. Studley, Milwaukee
Recording secretary—Mrs. R. C. Pfeil, Milwaukee
Treasurer—Mrs. Charles Fidler, Milwaukee
Directors—Mmes. H. J. Cannon, W. B. Ford, G. H. Friedman, W. F. Grotjan, V. F. Lang, W. C. Liefert and R. E. McDonald, all of Milwaukee.

Appointees to 1940 committees were announced as follows; all are of Milwaukee:

Program
Mrs. R. D. Bergen, chairman
Mrs. J. H. Sure, co-chairman

Music
Mrs. M. E. Gabor, chairman
Mrs. John R. Dundon, co-chairman

Local press and publicity
Mrs. E. H. Rettig, chairman

State publicity
Mrs. Gerald H. Friedman, chairman
Mrs. Harold J. Cannon, co-chairman

Membership
Mrs. George J. Pugh, chairman
Mrs. H. J. Farrell, co-chairman

Budget
Mrs. R. E. McDonald, chairman

Archives
Mrs. A. R. F. Grob, chairman

Historian
Mrs. V. F. Lang

Philanthropic
Mrs. Joseph Lettenberger, chairman
Mrs. R. D. Champney, co-chairman

Courtesy
Mrs. Paul A. Lee, chairman
Mrs. Henry S. Smith, co-chairman

Public relations
Mrs. R. D. Champney, chairman
Mrs. W. M. Jermain, co-chairman

Social and lobby hostess
Mrs. T. M. Northey, chairman
Mrs. V. L. Baker, co-chairman
Mrs. David E. W. Wenstrand, co-chairman

Education
Mrs. Edward M. Lawler, chairman
Mrs. R. P. Gingrass, co-chairman

Hygeia
Mrs. Maurice Hardgrove, chairman
Mrs. G. O. Dunker, co-chairman

Visiting nurse
Mrs. U. A. Schlueter, chairman
Mrs. J. A. Froelich, co-chairman

Telephone
Mrs. Paul G. Hankwitz, chairman
Mrs. R. W. Garens, co-chairman

The new president, Mrs. C. D. Partridge, introduced the music chairman, Mrs. M. E. Gabor, who played two delightful piano numbers. Mrs. Benjamin Lieberman, another auxiliary member, played two colorful violin selections; her accompanist was Mrs. H. P. Ringler.

Mrs. R. D. Bergen, program chairman, presented Mr. Phil Grau whose talk on "What's Behind the News?" brought forth enthusiastic response. After this splendid entertainment a buffet supper was served. White bowls of variegated spring flowers decorated the long table on a raised platform, at which the officers were seated. Members sat at small tables which were decorated with vases of spring flowers harmonizing with those at the officer's table.

Three new members were introduced, Mmes. C. F. Broderick, B. J. Malnekoff and H. L. Miller.

A member of the auxiliary to the Medical Society of Milwaukee County, Mrs. Frances Werner Sherwood, died on January 4 after an illness of about one year. Mrs. Sherwood, the wife of Dr. M. W. Sherwood, Milwaukee surgeon, was active in welfare, charity and medical organizational work. She was 44 years of age.

Polk

The annual meeting of the Woman's Auxiliary to the Polk County Medical Society was held in Osceola on December 14, with Mrs. L. O. Simenstad as hostess. Following dinner at the Osceola Hotel with members of the medical society, Mrs. A. N. Nelson, Clear Lake, introduced the speaker, Dr. William A. O'Brien of the University of Minnesota. Dr. O'Brien spoke on "Socialized Medicine." Following this talk, Dr. W. B. Cornwall, Amery, entertained both the auxiliary and medical society groups with a travel talk and movies of a trip he made to Alaska.

At a business meeting, held at the home of Dr. and Mrs. L. O. Simenstad, the following were elected officers for the ensuing year:

President—Mrs. A. N. Nelson, Clear Lake
President-elect—Mrs. Esther Andrews, Frederic
Secretary—Mrs. George B. Noyes, Centuria
Treasurer—Mrs. L. C. Gilman, Osceola

Guests at the meeting were Mrs. William A. O'Brien and Mrs. L. A. Boise of St. Paul.

Rock

Covers were laid for twenty-two at the pre-Christmas dinner party of the Woman's Auxiliary to the Rock County Medical Society held at the

home of Dr. and Mrs. H. E. Kasten, Beloit, in a beautiful holiday setting. Guests were greeted by a lighted tree on the porch and attractive festoons of green indoors. Dinner was served at 7 p. m. at small tables lighted by green pine cone candles.

After the dinner, bridge was played, a short business session held, and about sixty packages were presented by the members to be given to patients at Pinehurst Sanatorium, Janesville.

Sheboygan

At its first meeting of the new year—a 1 p. m. luncheon meeting at the Hotel Foeste, Sheboygan —members of the auxiliary to the Sheboygan County Medical Society heard an inspiring and informative talk on the life of Sir William Osler, presented by Dr. J. W. McRoberts, Sheboygan. Dr. McRoberts' talk was followed by a business session in charge of Mrs. Walter Ford, president of the auxiliary.

On January 23, the auxiliary held a card party at the Sheboygan Memorial Hospital to raise funds to place Hygeia in schools of Sheboygan county. The auxiliary's Hygeia committee was in charge of arrangements for the party. On the Hygeia committee are Mrs. A. J. Brickbauer, Plymouth, chairman; Mrs. I. M. Bemis, Adell; Mrs. Wesley W. Van Zanten, Mrs. Willard Huibregtse, Sheboygan; and Mrs. H. J. Hansen, Sheboygan Falls.

Washington—Ozaukee

The Woman's Auxiliary of the Washington–Ozaukee County Medical Society met at the Republican House, Kewaskum, November 16, 1939. Officers for the coming year were elected as follows:

President—Mrs. A. H. Barr, Port Washington
President-elect—Mrs. A. H. Heidner, West Bend
Secretary-treasurer — Mrs. P. B. Blanchard, Cedarburg

December 14, an interesting meeting of the auxiliary was held in West Bend. Luncheon at the Beacon restaurant was followed by a business meeting and bridge at the home of Mrs. J. E. Reichert. The president appointed the following to serve on committees for 1940:

Program
Mrs. A. H. C. Carthaus, Thiensville, chairman
Mrs. K. T. Bauer, West Bend
Mrs. F. W. Lehmann, Hartford
Mrs. H. M. Lynch, West Bend
Mrs. J. G. Hoffmann, Hartford

Public relations
Mrs. R. S. Fisher, Allenton, chairman
Mrs. K. F. Prefontaine, Slinger
Mrs. K. T. Bauer, West Bend

Hygeia
Mrs. H. M. Lynch, West Bend, chairman
Mrs. F. W. Lehmann, Hartford
Mrs. R. S. Fisher, Allenton
Mrs. J. E. Reichert, West Bend

Nominating
Mrs. O. J. Hurth, Cedarburg, chairman
Mrs. W. H. Drissen, Port Washington
Mrs. K. T. Bauer, West Bend

Press and publicity
Mrs. J. E. Reichert, West Bend, chairman
Mrs. K. T. Bauer, West Bend
Mrs. R. G. Edwards, Kewaskum
Mrs. C. H. Kalb, Grafton
Mrs. E. T. Monroe, Hartford
Mrs. M. E. Monroe, Hartford
Mrs. O. W. Hurth, Cedarburg

Archives
Mrs. A. H. Heidner, West Bend, chairman
Mrs. J. E. Reichert, West Bend
Mrs. A. H. C. Carthaus, Thiensville
Mrs. R. G. Edwards, Kewaskum
Mrs. T. J. Kern, Richfield

Membership
Mrs. W. J. Wehle, West Bend, chairman
Mrs. R. S. Fisher, Allenton
Mrs. C. H. Kalb, Grafton

Mrs. K. T. Bauer gave an interesting paper on socialized medicine taken from the article in the November, 1939, issue of the Wisconsin Medical Journal. Mrs. C. H. Kalb, Grafton, was welcomed into the organization as a new member.

On January 11 the auxiliary met at Richfield. A luncheon and business meeting at the Ben Dickel Hotel was followed by a social hour at the home of Mrs. T. J. Kern. Mrs. Barr, mother of Dr. Arnold Barr of Port Washington, was a guest at this meeting.

The auxiliary plans to hold its next meeting in March.

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Superior Cooperative Health Association Holds Subscribers' Mass Meeting

". . . our relations with the Wisconsin Medical Society and with the twenty-one doctors on our panel are of the very best. They are giving us their wholehearted cooperation. We regret to have to state this, but the fact is we have received better cooperation from the doctors than from the rank and file of the consumers, whom we counted on to join our organization." Thus Mr. Oscar Cooley, chairman of the Board of Directors of the Cooperative Health Association of Superior quoted from a lengthy letter to the directors of the several cooperative societies in Douglas county, when he addressed a mass meeting of 100 subscribers and others in the community who were interested in the cooperative health association. The executive committee of the board of directors of the Cooperative Health Association had authorized an appeal to the cooperative societies in Douglas county and the calling together of the subscribers to the association to discuss its critical membership condition.

Approximately 100 people attended the January 5 subscribers' mass meeting held in Superior. The audience was composed both of present subscribers to the association and others in the community who had heard of the meeting and were interested in the Cooperative Health Association.

The appeal for help which had originally been directed by officers of the Cooperative Health Association to the other cooperative societies was read in its entirety by Mr. Cooley. The appeal stated that this plan for the prepayment of medical care had been conceived by the cooperators in Douglas county but that, when the plan was offered, the people did not come forward and request membership in the association. "On the contrary," stated Mr. Cooley, quoting again from the letter to the directors of the cooperative societies, "we had to organize an intense promotional campaign and send out teams of canvassers and sell the plan to each individual member."

Mr. Cooley stated that the State Medical Society of Wisconsin had made up the overhead deficits of the organization and without this help it would have been impossible to operate; that the meeting had been called to consider, explore and perhaps develop some new means whereby 140 new subscribers could be induced to join the Association. With the acquisition of this many new subscribers, he pointed out, the maximum number permitted under the trial agreement would be reached. "This," declared Mr. Cooley, "is absolutely necessary if the plan is to succeed."

Mr. George Larson, assistant secretary of the State Medical Society, accepted the invitation extended to him by the executive committee of the Cooperative Health Association, and followed Mr. Cooley on the program. He was asked to present the Society's attitude toward the plan. "From the outset," declared Mr. Larson, "the primary interest of the medical profession has been to protect the health interests of those under any system of prepaid sickness care. It has been the position and the experience, proven by time, that the interest of the public in health matters and the interest of the profession are inseparable. In this, as in other proposals that have been advanced with the intent of promoting the health of the public, the profession has always urged and insisted that every care be exercised so that, by the very means it is hoped to promote the health of those affected, the opposite did not occur. . . The profession of medicine through the years, particularly of recent years, has seen the prepayment theory for the provision of medical care used to exploit patients from a financial standpoint, rather than promote the health of the subscribers.

"It is possible, you know," said Mr. Larson, "through the application of such a plan, to cheapen the service without the knowledge

of the subscriber. The organized medical profession does not know whether the prepayment insurance principle can be used and at the same time permit the safeguards, which are essential to good medical care and to the continued advance of medicine, to be preserved and retained.

". . . the profession," continued Mr. Larson, "looks upon this trial as it does upon the entire field of voluntary sickness insurance experimentation,—with the viewpoint of the student. To members of the medical profession this is one of three Wisconsin laboratories in which they can study this problem, just as they would study a medical illness in a laboratory with test tubes, microscopes, etc. To make possible this study room the doctors in Wisconsin have made funds available and the profession in Douglas county has made available its time and skill."

The attitude of the profession was further explained to the audience by quoting from a report adopted by the Douglas County Medical Society a few days earlier. A portion of that report states:

> "Your committee recommends that the cooperation of the Society be continued under this plan for the balance of the agreement period unless there is a request by the directors of the Cooperative Health Association that the plan be discontinued."

The executive committee of the Cooperative Health Association, as well as the directors and the manager—Mr. Bernard Gray—were commended by Mr. Larson for their industrious efforts during the year to enroll subscribers to the Association.

The meeting was then opened for general discussion and Mr. Arnold Rohn, manager of the Central Cooperative Wholesale, declared that from the newspaper and other publicity which had been given to the meeting they were to gather together to perform the last rites to the Association. He stated further that the attitude of the officers and others had given the meeting the complexion of a funeral service "to bury the Cooperative Health Association" and declared that such need not be the case; that there were many sources of membership possibilities that had not been worked to the fullest extent. He charged that the directors had

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not exerted the fullest possible efforts to enroll members. He asserted there should be no difficulty in enrolling the maximum number of 300 units from among the estimated 2,000 cooperative families in Douglas county. Others in executive positions in the cooperative societies discussed the health association and pledged their support to securing new members.

Upon motion by Mr. Rohn of the Central Cooperative Wholesale, a committee of nine volunteers was called from among the audience to make an intensive solicitation campaign among the cooperative people in Superior to join the association.

A report received from the officers of the Cooperative Health Association indicated that thirty-four new units have been enrolled under the plan through the combined efforts of the manager, the executive committee of the Board of Directors and the volunteer committee from the subscribers. Of the thirty-four units indicating a willingness to participate, ten fulfilled all the membership requirements and became eligible for service on February 1.

Council on Scientific Work Arranges Spring Clinic Days Program

THE annual spring clinic days arranged by the Council on Scientific Work of the State Medical Society of Wisconsin will be held in Wausau on April 24, Watertown on April 25 and La Crosse on April 26. These dates and locations were set by the Council on Scientific Work at its meeting in Madison on Wednesday, January 10, at which time the program for the spring clinics was discussed and approved.

Dr. James A. Evans, the member of the Council on Scientific Work in charge of the preparation of the spring clinic days program, reported that he had been able to secure outstanding men to present this graduate material to members of the Society this spring.

In arranging the program, the Council on Scientific Work provided that the morning sessions would be devoted to dry clinics, and the afternoon sessions to lectures. The dinner hour from 6 p. m. to 8 p. m. will be arranged so as to provide informal round table conferences on surgery, obstetrics, pediatrics and medicine. At the evening sessions there will be presented outstanding discussions of general interest.

The "team" which will appear in each of the three cities is as follows:

Coordinating Chairman:

William S. Middleton, M.D., Madison
University of Wisconsin Medical School.

Medicine:

Samuel A. Levine, M.D., Boston
Senior Associate in Medicine, Peter Bent Brigham Hospital, and Assistant Professor of Medicine, Harvard Medical School.

Merrill C. Sosman, M.D., Boston
Assistant Professor of Roentgenology, Harvard Medical School.

William D. Stovall, M.D., Madison
Director, State Laboratory of Hygiene, Madison, and Acting Superintendent, Wisconsin General Hospital.

Pediatrics:

A. Graeme Mitchell, M.D., Cincinnati
Professor of Pediatrics, Cincinnati School of Medicine, and Chief of Pediatric Service, Cincinnati Children's Hospital.

Obstetrics:

John W. Harris, M.D., Madison
Professor of Obstetrics, University of Wisconsin Medical School.

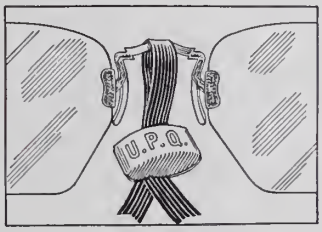
Dermatology and Syphilology:

Paul A. O'Leary, M.D., Rochester
Professor of Dermatology, University of Minnesota.

Surgery:

Geza de Takats, M.D., Chicago
Associate Professor of Surgery, University of Illinois College of Medicine.

A complete program will appear in the March issue of the WISCONSIN MEDICAL JOURNAL giving the special topics to be presented, as well as an hour-by-hour schedule of the program. Circle the date on your calendar now and plan to attend this outstanding program of modern medicine which will be brought to your door in April.



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The Journal Bookshelf

BOOKS RECEIVED FOR REVIEW

Diseases of the Foot. By Emil D. W. Hauser, M.S., M.D., assistant professor of bone and joint surgery, Northwestern University Medical School; attending orthopedic surgeon, Passavant Memorial Hospital, Chicago. With a foreword by Sumner L. Koch, M.D. Cloth. Price, $6. Pp. 472, with 263 illustrations, some in colors. Philadelphia: W. B. Saunders Company, 1939.

Office Gynecology. By J. P. Greenhill, B.S., M.D., F.A.C.S, professor of obstetrics and gynecology, Loyola University Medical School; professor of gynecology, Cook County Graduate School of Medicine; attending gynecologist, Cook County Hospital; editor of "Gynecology" in the Year Book of Obstetrics and Gynecology and author of Obstetrics for the General Practitioner Cloth. Price, $3. Pp. 406, with 106 illustrations. Chicago: Year Book Publishers, 1939.

The Health Insurance Doctor, His Role in England, Denmark and France. By Barbara N. Armstrong, Princeton, N. J. Cloth. Price, $3. Pp. 277. Princeton, N. J.: Princeton University Press, 1939.

Treatment by Manipulation. By A. G. Timbrell Fisher, M.C., M.B., Ch.B., F.R.C.S. (Eng.), co-trustee and member of executive and research advisory committees of Empire Rheumatism Council; corresponding member of the American Academy of Orthopaedic Surgeons; Orthopaedic Surgeon to the St. John Clinic and Institute of Physical Medicine and to the Arthritic Unit, St. Stephen's Hospital (L.C.C.); formerly Hunterian professor of the Royal College of Surgeons of England; vice-president, Orthopaedic Section, B.M.A. meeting, Oxford, 1936; assistant, surgical unit, University College Hospital; clinical assistant, orthopaedic department, St. Bartholomew's Hospital; surgical specialist, R.A.M.C. and ministry of pensions, etc. Ed. 3. Cloth. Price, $3.75. Pp. 255, with 68 illustrations. New York: Paul B. Hoeber, Inc., 1939.

Fractures. By Paul B. Magnuson, M.D., F.A.C.S., associate professor of surgery, Northwestern University Medical School; attending surgeon, Passavant Memorial Hospital and Wesley Memorial Hospital, Chicago. Cloth. Price, $5. Ed. 3 Pp. 511, with 317 illustrations. Philadelphia: J. B. Lippincott Company, 1939.

Cancer of the Larynx. By Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S., honorary professor of broncho-esophagology and consultant in broncho-esophagologic research, Temple University Medical School, Philadelphia, and Chevalier L. Jackson, A.B., M.D., Mc.Sc. (Med.), F.A.C.S., professor of broncho-esophagology, Temple University Medical School, Philadelphia. Cloth. Price $8. Pp. 309 with 189 illustrations and 5 color plates. Philadelphia: W. B. Saunders Company, 1939.

Tumors of the Skin. By Joseph Jordan Eller, M.D., attending dermatologist, City Hospital, New York City; and consulting dermatologist, French Hospital, Broad Street Hospital, New York; Morristown Memorial Hospital, Monmouth Memorial Hospital, Fitkin Memorial Hospital, New Jersey; Norwalk General Hospital, Conn.; Unity Hospital, Brooklyn; Morelos Hospital, Mexico, etc. Cloth. Price, $10. Pp. 607, illustrated with 403 engravings. Philadelphia: Lea & Febiger, 1939.

Psychopathia Sexualis: A Medico-Forensic Study. By Richard Von Krafft-Ebing, M.D., professor of psychiatry and nervous diseases, University of Vienna. Cloth. Price, $3. Ed. 12. Pp. 626. New York: Pioneer Publication, Inc., 1939.

The 1939 Year Book of General Medicine. Edited by George F. Dick, M.D., J. Burns Amberson, Jr., M.D., George R. Minot, M.D., S. D., F.R.C.P., William B. Castle, M. D., A. M., William D. Stroud, M.D., and George B. Eusterman, M.D. Cloth. Price, $3. Pp. 848, illustrated. Chicago: The Year Book Publishers, 1939.

The Vitamins: A symposium arranged under the auspices of the Council on Pharmacy and Chemistry and the Council on Foods of the American Medical Association. Cloth. Price $1.50. Pp. 637. Chicago: American Medical Association, 1939.

An Introduction to Gastro-Enterology. By Walter C. Alvarez, M.D., professor of medicine, University of Minnesota, The Mayo Foundation, and a senior consultant in the Division of Medicine, The Mayo Clinic. Ed. 3 of The Mechanics of the Digestive Tract. Cloth. Price, $10. Pp. 778 with 186 illustrations. New York: Paul B. Hoeber, Inc., 1940.

Electrocardiogram and X-ray Configuration of the Heart. By Arthur M. Master, B.S., M.D., F.A.C.P., associate in medicine and chief, cardiographic laboratory, the Mt. Sinai Hospital, New York; associate in medicine, the College of Physicians and Surgeons, Columbia University, New York. Cloth. Price, $6.50. Pp. 222, illustrated with 71 figures and 100 plates. Philadelphia: Lea & Febiger, 1939.

Tumors of the Hands and Feet. Edited by George T. Pack, B.S., M.D., F.A.C.S., New York City, assistant clinical professor of surgery, Yale University School of Medicine and Cornell University College of Medicine; attending surgeon, Memorial Hospital for Cancer and Allied Diseases. Cloth. Price, $3. Pp. 138, illustrated. St. Louis: The C. V. Mosby Company, 1939.

Accepted Foods and Their Nutritional Significance. By the Council on Foods of the American Medical Association. Cloth. Price, $2. Pp. 492. Chicago: American Medical Association, 1939.

A Symposium on the Blood and Blood-Forming Organs: Addresses given at an Institute Conducted by the Medical School of the University of Wisconsin, September 4–6, 1939. Cloth. Price, $3.50. Pp. 264, illustrated. Madison, Wis.: The University of Wisconsin Press, 1939.

Short Stature and Height Increase. By C. J. Gerling. With a foreword by Edward Podolsky, M.D. Cloth. Price, $3. Pp. 159, illustrated. New York: The Harvest House, 1939.

Handbook of Skin Diseases. By Leon H. Warren, B.A., M.D., M. Sc. (Med.), formerly instructor in dermatology and syphilology at the School of Medicine, Temple University; Acting Assistant surgeon (dermatology) in the office of Dermatoses Investigation of the United States Public Health Service; assistant dermatologist, Philadelphia Methodist Hospital. With a foreword by Frederick D. Weidman, M.D. Cloth. Price, $3.50. Pp. 321. New York: Paul B. Hoeber, Inc., 1940.

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Cancer of the Breast and Cancer of the Uterus. Ed. 2. By Marion E. Anderson, A.B., M.D., Clinton, Ia. Cloth. Price, $3.50. Pp. 106, illustrated. Clinton, Ia: The Franklin Press, 1939.

The Patient's Dilemna. By Hugh Cabot, M.D., Needham, Mass. Cloth. Price, $2.50. Pp. 284. New York: Reynal & Hitchcock, 1940.

The 1939 Year Book of General Surgery. Edited by Evarts A. Graham, A.B., M.D., professor of surgery, Washington University School of Medicine, surgeon-in-chief of the Barnes Hospital and of the Children's Hospital, St. Louis. Cloth. Price, $3. Pp. 796, illustrated. Chicago: The Year Book Publishers, 1939.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Experimental Pharmacology and Materia Medica. By Dennis E. Jackson, Ph.D., M.D., F.I.C.A., Cincinnati, Ohio, professor of pharmacology, materia medica and therapeutics, University of Cincinnati College of Medicine. Ed. 2. Cloth. Price, $10. Pp. 906 with 892 illustrations, including 55 color plates. St. Louis: The C. V. Mosby Company, 1939.

The first edition of this book was published in 1917. The author has used the same experimental approach to the subjects of pharmacology and materia medica in this, the second edition. Explicit directions are presented for conducting animal experiments and for compounding prescriptions with most of the important drugs used in present day therapy. A wealth of information of a technical nature is to be found, such as anatomical diagrams and directions for the use and construction of apparatus. Unfortunately, relatively little concise data regarding the pharmacodynamic actions of drugs are included. The student reader would have to use supplementary sources to find direct answers to his questions concerning drug actions even if he were to devote much attention to the numerous representative graphs which are included. The material is hardly of such a nature as to appeal to the practicing physician but the teacher and experimenter will find this volume to be of great practical value. M. H. S.

Textbook of Nervous Diseases. By Robert Bing, professor of neurology, University of Basel, Switzerland. Translated and enlarged by Webb Haymaker, assistant clinical professor of neurology and lecturer in neuro-anatomy, University of California. From the fifth German edition. Cloth. Price, $10. Pp. 830, with 207 illustrations including nine in color. St. Louis: The C. V. Mosby Company, 1939.

The fifth edition of this excellent text is the first available to the English reading physician. It has been fully revised and is considerably larger than the previous German editions. Throughout, the translator has been successful in maintaining simplicity and clarity of style and of composition which makes for facile and enjoyable reading.

This English edition of Professor Bing's work differs from the majority of present American textbooks of neurology in that the neurological material is more extensive, complete and up to date, and the space devoted to therapy is considerably greater. In addition, the material is almost entirely clinical and no attempt is made to present detailed and theoretical anatomical, physiologic and pathologic considerations. Throughout, these are discussed briefly and factually as they apply to the various clinical entities. Several chapters are devoted to the psychoneuroses.

The text is recommended for students of clinical neurology and as a reference for the practitioner. The few undesirable features and the quality of some of the illustrations will undoubtedly be improved in subsequent editions. These do not detract from the value of the book. M.J.M.

Diseases of the Skin. By Richard L. Sutton, M.D., Sc.D., LL.D., F.R.S. (Edin.), professor of dermatology, University of Kansas, School of Medicine; and Richard L. Sutton, Jr., A.M., M.D., L.R.G.P. (Edin.), associate in dermatology, University of Kansas, School of Medicine. Ed. 10, revised, enlarged and reset. Cloth. Price, $15. Pp. 1549, with 1452 text illustrations and 21 color plates. St. Louis: The C. V. Mosby Company, 1939.

The tenth edition of this well known work is a large volume of some 1500 pages. Moreover the material in it has been so efficiently arranged and printed that there has been effected a 100 per cent increment in the number of words used. Furthermore this has permitted the inclusion of some 7000 bibliographic references along with the authors' comments on same. Several new color plates and several hundred new illustrations adorn this new volume which makes the total number of color plates 21 and the number of illustrations 1452.

The material itself is, as usual, described in a series of some twenty-two chapters. The first eight chapters, which together take 136 pages, are concerned with anatomy, embryology, physiology, symptomatology, pathology, etiology and treatment. This is all presented in the usual customary form, but it has all been revised and rewritten to bring it up to date, and thus it differs markedly from the same descriptions found in the earlier editions.

The balance of the book is devoted to descriptions of cutaneous diseases. The authors have here arranged the material in accordance with their etiological classification of 1937 and in accordance with what seems to be considered a new thought in dermatology; namely "that the processes of pathology are, in general, inevitable responses under the circumstances." There are chapters on inflammation, purpuras, metabolic dermatoses, atrophies, neuroses, anomalies of pigmentation, malformation, new growths, virus diseases, diseases due to bacteria, diseases due to higher fungi, diseases due to animals, diseases particularly affecting the cutaneous appendages and diseases of the mucosae adjoining the skin. The authors have included descriptions of unusual and rare conditions, and of all those syndromes and concepts which are of any significance. They have given freely of their personal opinions

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*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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and the chatty person-to-person style of earlier editions has been reduced to a minimum. The book is a valuable one for the special students as well as the general practitioners of medicine. R. L. M.

Anatomy and Physiology. By Frederic Theodore Jung, B.S., Ph.D., M.D., assistant professor of physiology and pharmacology, Northwestern University Medical School; member of visiting staff, Norwegian American Hospital, Chicago. In collaboration with Anna Ruth Benjamin, B.A., M.D., resident physician, Elgin State Hospital, Elgin, Illinois; and Elizabeth Carpenter Earle, B.A., R.N., educational director, school of nursing, St. Elizabeths Hospital, United States Department of Interior, Washington, D. C., president of the District of Columbia League of Nursing Education. Cloth. Price, $3.50. Pp. 637, with 342 illustrations. Philadelphia: F. A. Davis Company, 1939.

The authors state that their aim in writing this textbook of anatomy and physiology is to "make the subject matter both interesting and practical * * * to steer a middle course between brevity and fullness, to achieve both clarity and vividness." It seems to me that they have held consistently to these objectives and have carried them out skilfully.

The book is very readable; the style is definite and readily understood; the type is large and clear. The division of the page vertically into short horizontal lines somewhat facilitates rapid reading. The illustrations and photographs are well chosen to clarify the descriptions and explanations.

An effort has evidently been made to correlate anatomical and physiological facts with well-known realities of life and with the principles of chemistry, physics, and other sciences. In the chapter on "Physiology of Tissue" a clear explanation of osmosis serves to explain the action on body cells of surrounding fluids of various osmotic pressures. The chapter on the "Muscles of the Extremities" contains drawings which illustrate the relation between the shape and position of the bones of the foot and weight-bearing by the foot.

Since the study of anatomy and physiology necessarily deals with the physical composition and action of the average individual, it seems fitting that such a study should be introduced by a chapter which presents mainly the dissimilarities among men. The first chapter "Man as a Whole" gives statistically and verbally many examples of the lack of conformity of human beings with the so-called "normal." The method employed in this chapter of first introducing a subject as a whole and later elaborating upon each of its various aspects materially increases the ability of the reader to understand and retain the information offered.

The accuracy of the information contained in this book is attested to by the positions and achievements of the authors. The book is not so full of scientific facts as to be of use to a specialist in the field only. Its simplicity and completeness and its many applications to her life, both personal and professional, should make this book a valuable addition to the library of any nurse. G.S.

Menstrual Disorders. By C. Frederic Fluhmann, B.A., M.D., C.M., associate professor of obstetrics and gynecology, Stanford University School of Medicine, San Francisco, California; assistant visiting obstetrician and gynecologist to Lane and Stanford University Hospitals; Fellow of the American Gynecological Society. Cloth. Price, $5. Pp. 329, with 119 illustrations. Philadelphia: W. B. Saunders Company, 1939.

This volume is an excellent and complete discussion of menstruation. It deals not only with the pathology, diagnosis and treatment of menstrual disorders, but includes a historical review of conception, menstruation and the physiology of menstruation. The pathology and treatment of menstrual difficulties is discussed with as great a thoroughness as it is possible at the present time in the light of our knowledge. This is the best monograph on the problem which is available today. It should be in the library of every general practitioner. M.J.T.

Practical Obstetrics. By P. Brooke Bland, M.D., emeritus professor of obstetrics, Jefferson Medical College; consulting obstetrician, Jefferson Medical College Hospital, Philadelphia, Pa., and Thaddeus L. Montgomery, M.D., clinical professor of obstetrics, Jefferson Medical College, Philadelphia, Pa. Ed. 3. Cloth. Price, $8. Pp. 877, illustrated with 502 engravings, including twenty-seven colored plates. Philadelphia: F. A. Davis Company, 1939.

This textbook is very complete and well organized. It is a book that can be recommended to the teaching of medical students as well as practitioners of obstetrics. The authors are to be commended upon this excellent book. R.E.C.

Modern Clinical Psychiatry. By Arthur P. Noyes, M.D., superintendent, Norristown State Hospital, Norristown, Pa. Ed. 2, rewritten and enlarged. Cloth. Price, $5. Pp. 570. Philadelphia: W. B. Saunders Company, 1939.

The second edition of Dr. Noyes' Modern Clinical Psychiatry is to be recommended highly to the student as well as the practitioner. The author's arrangement of material together with descriptions of mental mechanisms, symptoms of mental disease, and examination of the patient are especially desirable. It is refreshing to find the general biological approach which this author gives to most of these subjects. The second edition represents a rather extensive revision of certain chapters in the first appearance of the book. These revisions indicate the author's appreciation of growing scientific trends in modern psychiatry. A.C.W.

The 1939 Year Book of General Surgery. Edited by Evarts A. Graham, A.B., M.D., professor of surgery, Washington University School of Medicine, surgeon-in-chief of the Barnes Hospital and of the Children's Hospital, St. Louis. Cloth. Price, $3. Pp. 796, illustrated. Chicago: The Year Book Publishers, 1939.

The 1939 Book of Surgery is again the most outstanding review of contributions during the past year to the field of surgery. It contains abstracts of all of the newer advances both in diagnosis and treatment. It is highly recommended to anyone interested in the field of surgery. K.E.L.

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(Continued from page 110)

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POWERFUL GROUPS

The Washington News Letter on Social Legislation, whose editorial offices are in Washington, D. C., indicated in its January 17, 1940 issue that "powerful groups" are hard at work to push through Congress a national health bill.

The Washington News Letter on Social Legislation contained the following paragraph:

"Josephine Roche's Interdepartmental Committee to Coordinate Health and Welfare is now working on a proposal in line with the President's hospital suggestion. The plan calls for Federal construction of a number of small hospitals—perhaps 50—costing about $150,000 each to construct and equip. The powerful groups interested in a *real* national health program, while approving this are unlikely to regard it as an adequate substitute for the Wagner Bill." (Italics ours.)

Apparently the Washington News Letter on Social Legislation does not construe the President's hospital program as any *real* health program. The only *real* national health program to powerful groups would be completely socialized or compulsory sickness insurance.

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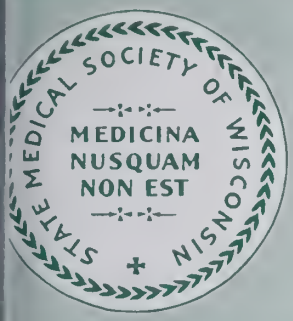

Spring Graduate Clinics

April 24-25-26, 1940

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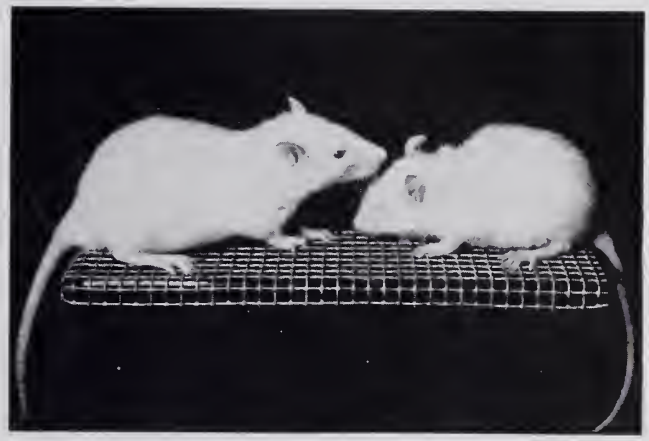
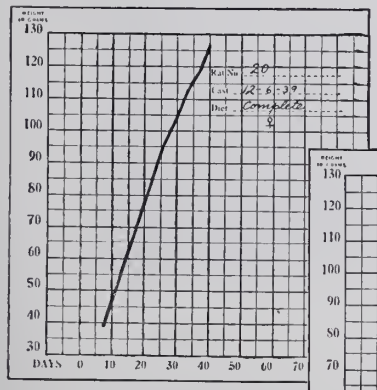
STUDIES IN THE AVITAMINOSES

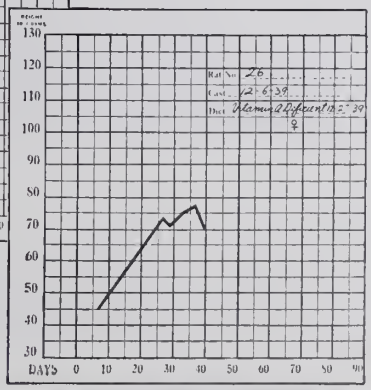
This page is the third of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the March 9 issue of The Journal of the American Medical Association.

INHIBITION of growth in the rat produced by restriction of vitamin A in the diet. The animals, litter mates, were 21 days old at the start of the experiment which was continued for 33 days. The animal at right received a diet containing all nutritive substances except vitamin A; the animal at left, an adequate diet. Note the xerophthalmia in vitamin A deprived rat.



Retardation of Growth Due to Vitamin A Deficiency





The upper graph records the growth of a rat on a complete diet. The lower graph records the growth of a litter mate on a vitamin A deficient diet; it depicts almost immediate retardation and cessation of growth.

While vitamin A is no more essential for growth than are other indispensable nutritional factors, its deprivation leads to well-defined growth retardation in man as well as in experimental animals. This action is so predictable that it is employed as a basis for one of the methods of vitamin A assay. The immediate effect of vitamin A deficiency on growth is cessation of endochondral bone formation. The curves reproduced illustrate the prompt growth-inhibiting effect of vitamin A deprivation in rats.

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Volume XXXIX
Number 3

MADISON, WISCONSIN, MARCH, 1940

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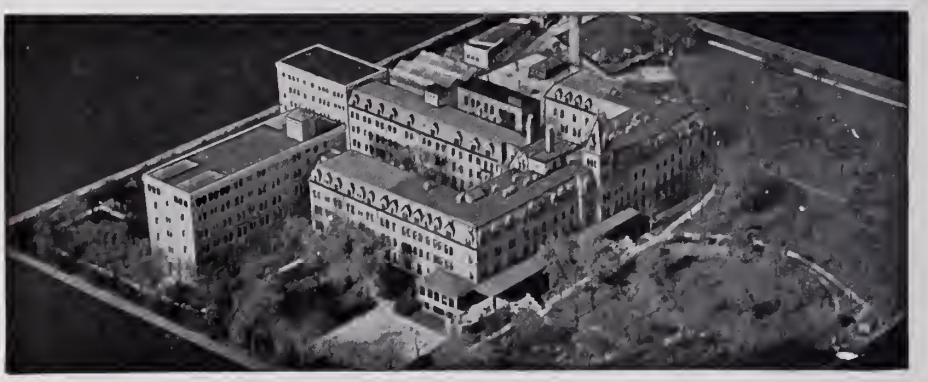

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METHODS FOR QUANTITATIVE ESTIMATION OF THE VITAMINS

VI. Measurement of the P-P Factor (Nicotinic Acid)

● Early investigations by the U. S. Public Health Service demonstrated that pellagra may be prevented or cured by dietary regulation. Human subjects confined to an institutional diet known to produce pellagra, were completely protected from this disease by proper supplementation of the institutional diet (1). Ultimately, the existence of the P-P or Pellagra-Preventive factor was established (2).

From the similarity in natural distribution of the dietary factors effective in the control of human pellagra and canine blacktongue—as well as the pathology of these two diseases—the working hypothesis that canine blacktongue is the analogue of human pellagra was adopted (2). Techniques (2, 3) were devised for estimating the pellagra-preventive value of foods by feeding tests with dogs and the results checked by clinical observations with human subjects. The ability of a food to supplement basal diets—known to produce canine blacktongue or human pellagra—so as to prevent or delay the development of characteristic symptoms were the criteria employed for judging the P-P values of foods. Such tests using dogs or human subjects are still the most reliable methods for measuring the P-P potencies of foods (4, 5).

Although pellagra-producing diets may frequently be deficient in a number of essential nutrients (4, 6), the value of nicotinic acid or nicotinic acid amide for the treatment of the specific symptoms of blacktongue or pellagra is well established (7, 8). Recognition of the importance of nicotinic acid in human nutrition created a definite need for rapid methods of estimating the nicotinic acid content of foods. The possibilities of the reaction between nicotinic acid, cyanogen bromide and aromatic amines as a basis of a colorimetric method for estimating nicotinic acid are receiving consideration (9). However, cyanogen bromide and aromatic amines may react with a number of compounds containing the pyridine ring to produce a yellowish green color. Therefore, it is essential that the specificity of any method for nicotinic acid be clearly established before nicotinic acid values determined by the method can be accepted as indicative of the pellagra-preventive values of foods.

Permanent control of endemic pellagra will require inclusion of a larger number of the protective foods in the pellagrin's diet (4, 6). General improvement of diets by this means will serve to correct not only deficiencies of the P-P factor, but of other essential factors, as well. The value of commercially canned foods in a program designed to correct pellagra—as well as its attendant or secondary dietary deficiencies —might well be emphasized.

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(1) 1915. U. S. Pub. Health Reports 30, 3117.
1923. Ibid 38, 2361.
(2) 1926. U. S. Pub. Health Reports 41, 297.
(3) 1928. U. S. Pub. Health Reports 43, 657.
(4) 1939. The Vitamins: A Symposium, page 297, Amer. Med. Assn., Chicago.
(5) 1934. U. S. Pub. Health Reports 49, 754.
(6) 1939. J. Am. Med. Assoc. 112, 2581.
1938. Ibid. 110, 1081.
1939. Am. J. Digestive Diseases 5, 807.
(7) 1937. J. Am. Chem. Soc. 59, 1767.
1938. J. Nutrition 16, 355.
(8) 1937. J. Am. Med. Assoc. 109, 2054.
1938. Ibid. 110, 622.
(9) 1938. Nature 141, 830.
1939. Biochem. J. 33, 264

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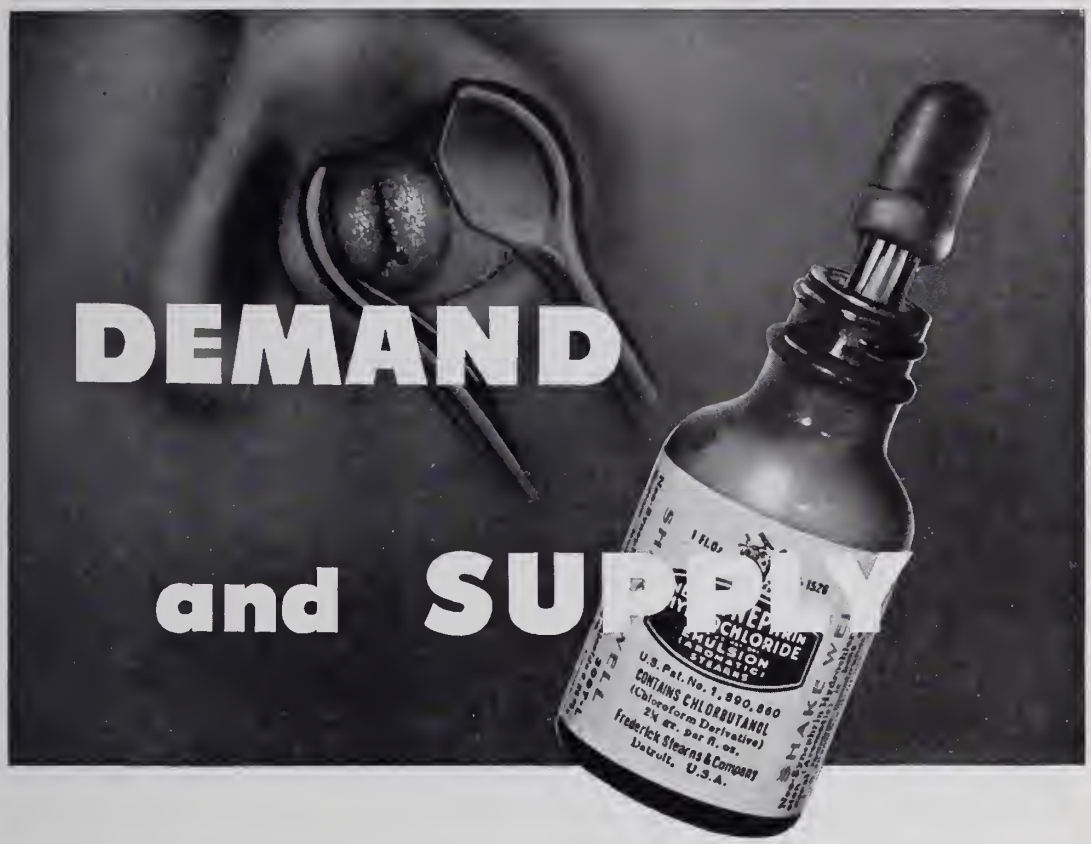

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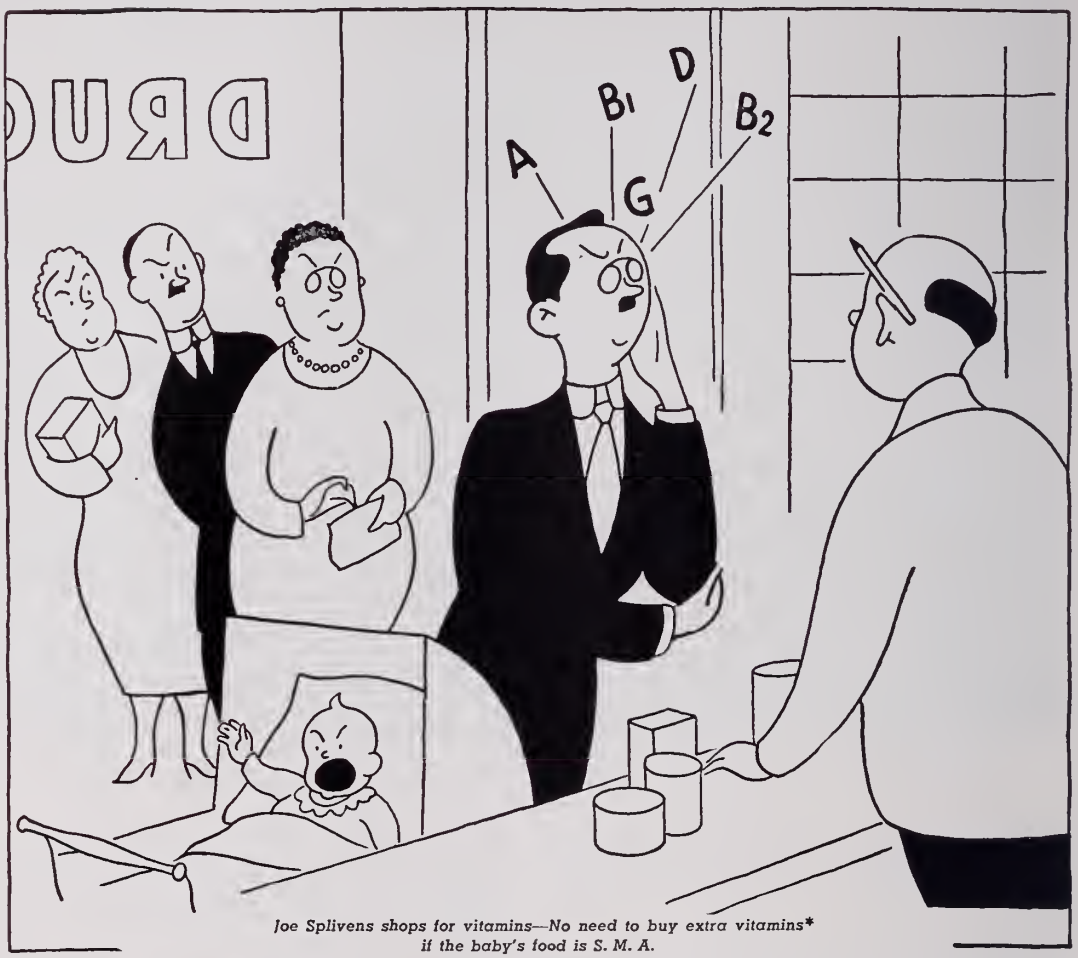

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THE WISCONSIN MEDICAL JOURNAL

VOLUME XXXIX, NO. 3 Copyright, 1940, by The State Medical Society of Wisconsin MARCH, 1940

The Early Diagnosis of Cancer in General Practice*

By M. FERNAN-NUNEZ, M. D.
Milwaukee

Medical Editor's Note.—The author of the following article, Dr. Fernan-Nunez, is the chairman of the State Society's Committee on Cancer, which in April will be requesting physicians throughout the State to assist the Women's Field Army of Wisconsin in the Army's annual cancer control campaign. The article represents *the least* every physician should know about cancer.

CANCER has become the second greatest health problem of today. Over 150,000 persons die of it each year in the United States. There are about 5,000 deaths from it yearly in Wisconsin, of which approximately 1,000 are in Milwaukee county.

There has been an apparent increase in cancer of 2 per cent a year. This is largely due to the increasing age of our population. In 1938 twice as many persons reached the age of greatest susceptibility to cancer (fourth, fifth and sixth decades) as in 1878. The decrease in immigration, the diminished mortality in childhood due to the control of infectious diseases, and the popularity of birth control practices are the most evident factors. Improved diagnostic acumen and an increase in autopsies are also revealing many cancers which in previous years were missed.

No age is immune. Cancer in children is generally overlooked until the condition is obvious. One per cent of all cancer occurs under 30 years of age, 3 per cent between the ages of 30 and 39, 18 per cent between 40 and 49, 31 per cent between 50 and 59, and 39 per cent between 60 and 69. The remaining 8 per cent occurs past the age of 70 years.

While well-equipped cancer institutes are of great value in managing cancer patients, any real decrease in cancer mortality must come from earlier diagnosis. In this the family physician is the logical agent as he is the first one consulted about lesions which molest or interest patients, many of which are potential malignancies. The physician must become extremely cancer conscious, must always consider the possibility of cancer in every patient coming under his care, and must fix his attention on the early danger signals of malignancy. Bloodgood aptly said, *"The life of the cancer patient depends on the first physician who sees and treats him."* Although cancer is the deadliest of all known diseases it is one of the easiest diseases to cure if treated in its early stages.

The public campaigns of the Women's Field Army against cancer are bringing into doctors' offices increasing numbers of patients who wish to avoid cancer by early diagnosis and treatment. Physicians must consider these patients seriously and give them the examinations and care that they seek lest they turn to the quacks and "irregulars."

Numerous attempts to work out a specific test for cancer have been made. Hemolytic, tinctorial, physicochemical, precipitation, flocculation, complement fixation, cytolytic, enzyme, biologic, skin, the Fuchs and the Elasser-Wallace tests have been devised. To date they have not proved sufficiently reliable for clinical use. The quantitative Aschheim-Zondek test in tumors of the testes and the Friedman test in choriocarcinoma in women might be classed as exceptions.

* From the department of pathology, Marquette University School of Medicine. Presented before the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

Under x-ray treatment, Ewing's tumor of bone, plasma-cell myeloma and lymphoblastomata often literally melt away for a while, and radiation can be used as a therapeutic test in these types of malignancy. An operation for a tumor should never be performed without a previous x-ray examination of the lungs for metastases.

For the accurate diagnosis of tissue, the biopsy is the method of choice. Properly done the biopsy offers very little chance of spreading the tumor, certainly much less than the usual palpation of a clinical examination where the pressure and squeezing may prove fatal.

My experience indicates that the clinical diagnosis of malignancies is correct in about 60 per cent of cases, while the biopsy diagnosis is accurate in approximately 90 per cent. In 7 per cent diagnosis has been impossible due to poor selection of the specimen, use of improper fixing fluid by the physician, the drying out of tissues, and other causes.

Pathologists are also physicians and the history of the patient is of much value and frequently necessary to a correct diagnosis of the specimen; the pathologic physiology of the patient is often of as much importance as is the pathologic anatomy. Such a history should include the patient's age, sex, occupation, exact anatomical site of the tumor, the date first noticed, and data on recent growth, changes in shape or color, signs of metatasis, previous removal, and the use of radiation or other specific therapy. The total and differential blood count, Wassermann or Kahn reaction, basal metabolic rate, and the results of Friedman tests should be given when possible. In women, the last menstruation date, the month of supposed pregnancy, the age of the last child, the history of the bleeding, and other pertinent facts should be stated.

Lip

Cancer of the lip is usually easily diagnosed. However, the possibility of certain other lesions being present must always be eliminated before the question of malignancy is finally determined. The pyogenic infections usually are readily cured by treatment. The lesion of tuberculosis commonly is but a part of the generalized disease. Syphilitic lesions generally progress rapidly and are responsive to antisyphilitic treatment; in their detection the Wassermann test of the blood is helpful. Cancer at the mucocutaneous juncture is almost entirely of the squamous cell type which has a strong tendency to metastasize. The basal-cell variety is commonly found away from the vermillion border of the lip.

The site of selection of a biopsy section is always of great importance. The central area of the lesion often shows infection, necrosis, ulceration or scarring. The periphery contains the most actively proliferating and characteristic histology of the tumor. Often too small a portion is obtained for proper diagnosis. *Biopsy of the lip should never be performed.* The entire lesion should be removed to permit the pathologist to study different areas of the growth. The mutilation is hardly greater than in the removal of any portion of the lesion, the danger of metastasis is obviated, and a second operation is not required if the lesion is a malignant one.

Breast

Any single nodule that can be felt in the breast of a patient, male or female, beyond the age of 25 years demands a microscopic examination unless the gross appearance is obviously malignant. The quadrant of the breast in which it is located is not important, except in the axillary quadrant where there is the possibility of earlier involvement of the lymph nodes.

A doctor's office is no place to remove a breast tumor. Such removal should be performed only under conditions where the proper measures can be immediately carried out if the nodule is found to be malignant. Such an ideal procedure is not always possible in small hospitals where frozen section examinations are not available. In such cases the operation should be completed if the gross appearance is at all suggestive of malignancy, the entire tumor removed with as wide a margin as possible around it and later submitted for microscopic diagnosis. A breast tumor should never be cut into and a piece of it taken out.

In excising small lumps which are to be sent to a distance for diagnosis, it is safer and easier to remove the segment of the breast which contains the tumor than to try to dissect the nodule out. In trying to dissect out a small nodule, the tumor is sometimes missed, the tissue sent to the pathologist shows nothing suspicious and the physician is at a loss to understand why the patient finally dies of cancer. Often he unjustly blames the pathologist for a mistaken diagnosis.

The majority of breast tumors can be diagnosed grossly, but a microscopic examination should always determine the final diagnosis. In borderline cases the pathologist is sometimes unable to decide when a condition is benign or malignant. When the pathologist is in doubt, the lesion usually is not malignant.

Chronic cystic mastitis is always to be considered a distinctly precancerous state. When a diagnosis of this condition is made the patient should be told to return for reexamination at the end of three weeks and to return every three months thereafter for a year.

The chest should always be roentgenographed for metastases in suspicious tumors of the breast, and, if there are "rheumatic pains" in other parts of the skeleton, especially the spine and pelvis, these should also be examined by means of x-rays. Subsequent death from metastases which were present at the time of operation is one cause of the low percentage of five-year cures following breast operations. Radical surgery is generally contraindicated when the metastases are present beyond the axillary lymph nodes.

Uterine Cervix

In the year 1938, over 18,000 women died from cancer of the uterus in the United States. Of these, approximately 90 per cent died of cervical cancer. Cancer of an advanced stage may occur in women apparently in the best of health, even in those who are obese. It is not uncommon in virgins. All cervical erosions, regardless of the age or status of the woman, should be treated as precancerous lesions. The cervix of every woman who bears a child should be reexamined a year later.

Pain is never an early symptom. It follows pressure on nerves and usually means that the cancer is incurable. The pain may be localized deep in the pelvis, in the lower spine, or referred down the legs. Burning and frequency of urination may result from invasion of the base of the bladder. Painful defecation may result from extension to the rectum and may be the only symptom. Within six months after the earliest symptoms appear, cancer of the cervix may generally be considered inoperable.

Early symptoms of cervical cancer seldom occur. Generally, by the time symptoms have appeared the lesion is moderately advanced. In 67 per cent of one series of 2,000 cases the only definite symptom was slight vaginal bleeding or "spotting," usually with a history of trauma from sexual intercourse, douching, straining at stool or exercise. The spotting character of the bleeding is very suggestive although rarely a frank hemorrhage may occur. Late symptoms are pain, cachexia and foul-smelling discharge.

Women must be made to understand that the occurrence of an unusual discharge or flow of blood demands the attention of a physician, and physicians must be made to realize that such symptoms demand of them the proof that cancer is not the cause. Only in this way can we make definite progress in the prevention of this common and deadly affliction.

Naturally bleeding will not arise until the cancer has been present long enough for ulceration to occur. Regular periodic examinations of women in the cancer age would enable us to discover cervical cancers at an earlier stage. The family physician owes it to his patients to insistently encourage them to undergo such periodic physical check-ups.

Bimanual and speculum examinations are usually sufficient for diagnosis of cervical cancers which are producing symptoms. Biopsy is the only method of diagnosing early cancer. Excising a piece of tissue for diagnosis carries with it little chance of spreading the disease, especially if the wound is cauterized. In this region there is much less

chance of a biopsy causing metastases than in the region of the breast.

The Schiller iodine test is particularly applicable for selecting tissue for biopsy. Lugol's solution is sponged liberally over the cervix. Due to the glycogen content of normal tissues, they will stain a brown tint. Areas that remain relatively uncolored should be selected for biopsy. It should be remembered that the iodine test is not a test for malignancy but serves only to locate a diseased area.

Two per cent of cervical cancers occur in cervical stumps following subtotal hysterectomy. While the performance of total rather than subtotal hysterectomy would seem to reduce this incidence, the mortality from total hysterectomy is higher than the percentage of cancer in cervical stumps. All stumps following subtotal hysterectomy should be carefully coned-out and the lower part of the canal cauterized to prevent malignancy.

It has been well said that *"The physician who allows his patient to go without prompt diagnosis may be sacrificing her life more surely than by failure to drain an appendiceal abscess."*

Body of the Uterus

Uterine body cancers present symptoms similar to those of cervical malignancy but of lesser degree and they usually appear at a later period of life. The cancer arises generally in the upper part of the uterus, grows slowly, and as a rule metastasizes much later than cervical cancer. This is due to the protection the thick uterine wall affords against trauma and to the relative sterility of the cavity of the uterus which delays infection and ulceration. A blood-tinged watery discharge is commonly the first sign.

Cancer of the body of the uterus seldom appears before the fortieth year, the average case occurring between 50 and 65 years. This is an unfortunate situation because the patient is likely to regard bleeding at this time as a return of the menses and to delay consultation with her physician for months. While cervical cancer usually kills within two years and is seldom curable after the sixth month, it is not unusual for cancers of the fundus of the uterus which have been present from one to two years to be cured. Adenocarcinoma may remain confined to the endometrium for many months before it penetrates the myometrium or metastasizes.

All too often vaginal bleeding is credited to a benign cervical polyp and the growth removed without further investigation. In such cases the uterine cavity should be curetted in order to deal with other polyps or possible uterine body carcinoma. Such curettage should be a thorough scraping as a neoplastic site can be missed easily by incomplete scraping. A senile uterus is easily perforated and all intrauterine manipulations must be done with care. Malignant curettings are firm, grayish and friable. Postmenopausal bleeding must never be considered a mere return of menstruation.

All patients who have passed a hydatidiform mole should have a Friedman test performed with the urine each month for a year to catch early any chorioepithelioma which might develop.

Stomach

A third of all carcinomas of men and a fifth of the carcinomas of women occur in the stomach. It is estimated that over 40,000 persons die of it each year in the United States. More deaths from cancer are due to cancer of the stomach than any other organ or region of the body.

Autopsy records show that about 22 per cent of stomach cancers are still confined to the stomach and that many of the deaths have resulted from perforation and peritonitis. Earlier diagnosis would bring to surgery many cases in which partial gastrectomy would be sufficient to save life. At present 28 per cent of operable cases are cured.

To make early diagnoses of cancer of the stomach the physician must think of its possibility in all instances in which the patient's attention has been attracted to his stomach. A patient who has reached the "tropic of cancer," say 35 years of age, who complains of indigestion, change in food habits, anorexia or other symptoms which cause him to seek medical advice, which are not immediately benefited by medical and dietary treatment and not clearly due to some other

organic or physiologic disorder, might well be subjected to a laparotomy to determine the possibility of cancer.

Gross hemorrhage is so rare in carcinoma of the stomach that as a symptom it has no value. Persistent occult blood in the stools, on the contrary, is a quite consistent feature and a diagnostic measure all too frequently neglected in patients under suspicion for this lesion. Gastric carcinoma early diminishes the gastric acidity, comforts the patient and often causes him to delay seeking medical care. *Unexplained anemias always call for a gastric study.*

So-called nervous indigestion is frequently seen in young persons but rarely in older people. A stomach which has resisted the dietary indiscretions and mental and nervous strains up to middle age would hardly break down unless attacked by some serious malady like cancer, cholelithiasis or cardiorenal failure.

The very newest aid to early diagnosis of cancer of the stomach is the flexible gastroscope. Calculated to "see around corners" it renders practically all parts of the lining of the stomach visible to the physician. Like other diagnostic instruments it requires proper training and extensive experience. Its field is probably quite limited as it is impossible to tell whether a gastric ulcer is malignant on gross examination. Pathologists not infrequently differ as to the presence of malignancy even after microscopic examination.

Relatively intangible symptoms require resort to x-ray examinations if we are going to make earlier diagnoses of cancer of the stomach. The patient and his doctor must realize that in such examinations the report will more often be negative and should not complain of the expense. Such patients should be thankful that their physicians have so well protected them with the chance of a cure if cancer be present. If the examination proves negative they should be glad to pay for the assurance of the absence of malignancy.

Rectum and Urinary System

Rectal cancer is fifth in frequency as compared with malignancy in any other part of the body. In a way this is fortunate since cancer of the rectum is readily accessible to diagnosis and treatment and a high percentage of cases should be curable.

Cancer of the rectum rarely gives any symptoms in its curable stage, and when symptoms do appear they are commonly attributed to other lesions, such as hemorrhoids. The symptoms given in textbooks are those of the end results, not of early findings. Any alteration in the bowel habits of a patient in the cancer age should call for immediate careful examination. *Any unexplained anemia suggests a colon and rectal study.* Every instance of bleeding from the rectum should be considered cancer until proved otherwise.

Diagnosis should be by examination. In no disease were Osler's words more applicable when he remarked that "*More mistakes are made by not looking than by not knowing.*" Complicated diagnostic instruments are not necessary. Probably 90 per cent of rectosigmoid cancers can be felt by digital examination. The proctoscope will reveal all growths within ten inches but the finger is more reliable than the proctoscope unless the physician is quite experienced in its use. *The slightest induration in the tissues felt by the finger should be carefully analyzed.*

Adenomatous rectal polyps are definitely precancerous lesions. The x-ray cannot be depended on in rectosigmoid cancers, especially if they are localized on the anterior or posterior wall. A lateral x-ray plate is sometimes helpful in detecting tumors of the lower section of the sigmoid.

A common mistake in taking biopsy specimens from the rectum is to secure the most accessible portions. The sessile papillomas are the same color as the mucosa, while in the pedunculated ones the base resembles the mucosa and the polyp itself is a darker red. The majority of postoperative specimens grade higher in malignancy than the biopsy specimen since in the former the base of the tumor and other more representative areas are examined. When the biopsy report is negative, the study should be repeated two or three times with material from different areas of the lesion.

Hematuria must be regarded as a symptom of malignancy in every patient, especially in those beyond the age of 45 years, unless some other cause for the hematuria is found. Hematuria from infections generally occurs before middle life.

First, the bladder should be explored with the cystoscope. Even so-called benign papillomas should be regarded as grade 1 carcinomas. Next, the kidneys should be studied by means of intravenous urography. Papillomata of the bladder are often transplants from growths in the kidney pelvis or ureters. Hematuria is commonly the first sign of a hypernephroma or other tumor of the kidney. X-ray examination should be made of the lungs for the characteristic "cannon-ball" metastases as well as for metastases in the bony structures.

Do not overlook the prostate in hematuria. In many cases of malignancy (scirrhous type) the prostate is smaller than normal. A single stony-hard spot presupposes cancer. Rarely the prostate is so soft and cellular that it can hardly be felt by the examining finger. If in doubt, an x-ray examination should be made of the heads of the femurs, pelvic bones and lumbar vertebrae, the most common sites for metastases. In an elderly man with a bone tumor, always investigate the prostate.

Respiratory System

Persistent hoarseness must be investigated. It may be a symptom of malignancy of the larynx, bronchi, lungs, esophagus, thyroid gland or mediastinum. Tumors in these organs often involve the recurrent laryngeal nerves to produce hoarseness or voice changes. Hemoptysis and/or a slight and increasing cough suggest cancer before tuberculosis.

Primary cancer of the lung develops as a rule in the walls of the bronchial branches and shows nothing characteristic in the skiagram. An endoscopic examination may make it possible to obtain a small piece of the growth or roughened mucosa for histologic study. Secondary tumors of the lung are more frequent than primary carcinomas, although the latter are much more common than generally believed, and are clearly shown on the x-ray plate. In an elderly patient with dyspnea and cough, without obvious cardiovascular disease or nephritis, pulmonary cancer will be the usual diagnosis. Primary cancers of the lung can often be successfully removed by surgery.

In laryngeal lesions of any kind cancer must be considered before syphilis. The physician should not wait to examine the larynx until dyspnea, aphonia, dysphagia or pain have appeared. Any patient within the cancer age who complains of laryngeal disturbance, and all patients who suffer with hoarseness of more than three weeks duration, should have a careful laryngeal examination. Early cancer of the larynx is just as curable as cancer elsewhere.

Bones

The physician should consider first the possibility of tumor metastases to bone as they are far commoner than primary tumors. Inquiry should be made concerning previous removal of tumors in any location. When a history of surgical treatment for tumor is obtained, an effort should be made to see the original microscopic preparation.

Leukocytosis may be increased in tumors, especially in Ewing's tumor. When present Bence-Jones urinary protein suggests multiple myeloma but may occur in metastatic carcinoma. A positive Wassermann reaction does not always mean syphilis is the cause but may justify a three weeks' therapeutic test with potassium iodide.

Under x-ray treatment Ewing's tumor, plasma cell myeloma and giant cell tumors respond readily and radiation should be tried first in all bone tumors as a therapeutic test. X-ray therapy should always be tried before operation, especially in every case of persistent, unexplained pain in a bone.

Biopsy should only be done as a last resort, when amputation is considered. In securing biopsy material be sure to obtain some of the real tumor tissue because much of the swelling is due to inflammatory reaction and the pathologist cannot make a proper diagnosis from it alone. Avoid the punch biopsy.

Beware of hasty incisions and curettage of benign tumors. Often a supposed osteomyelitis turns out to be a Ewing's sarcoma.

Cancer Prevention

The following study was made of the effectiveness of the campaigns of public education in cancer control:

(1) In the year 1933, the records of three hospitals in Racine county, Wisconsin, showed that 74 per cent of patients with cancer reached the hospitals in an incurable condition, the disease having already passed to other parts of the body. In 1938, five years later, only 63 per cent were found to be incurable on admission. This shows that, in Racine county, 11 per cent more persons with cancer are seeking treatment in the early stages of the disease than was the case five years previously.

(2) In the same hospitals it was found that the average age of patients with cancer of the breast was 53.2 years for the year 1928, while, in 1938, the average age was 50.1 years. This suggests that in the last ten years women with breast cancer have sought attention at an average of three years earlier.

(3) Combined statistics of four Milwaukee hospitals for 1923 show that 52 per cent of the patients with cancer of the breast went to their doctors too late. In 1938 only 12 per cent reached the hospitals in an incurable condition.

(4) In one large hospital during 1933, 72 per cent of the surgically treated cancer patients had tumors over one inch in diameter; in 1938 the average percentage of such patients with tumors over this size had dropped to 65. This indicates that, in 1938, 7 per cent more of the patients obtained early treatment than was the case five years previously.

(5) Recently in the same hospital the cancers seen were so small that biopsy was required three times more often than was the case ten years back, when cancers were so large that diagnosis was easier. The smaller the cancer the better the chances are of its cure. Many lives are definitely being saved by earlier diagnosis.

The Women's Field Army of the American Society for the Control of Cancer, in collaboration with the Committee on Cancer of the State Medical Society, is doing a splendid work in public education on cancer. Their slogan is "Early Cancer is Curable." These noble women deserve the support and encouragement of the medical profession in their beneficent crusade.

Comments on Pollen Therapy*

With Special Reference to Its Application in Wisconsin

By HOWARD J. LEE, M. D.
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THE purpose of this paper is to consider the specific management of allergic manifestations due to pollen. The syndromes seen are pollinosis or seasonal hay fever, seasonal bronchial asthma and, rarely, pollen dermatitis. It must be remembered that these seasonal conditions show no variation pathologically from the similar perennial disturbances.

It is estimated that between 2 and 3 per cent of the population of the United States are afflicted with either pollinosis or perennial hay fever annually. The two conditions may coexist or vary in their manner of appearance in the same patient during his lifetime.

Etiologic Factors

The most important predisposing factor in hay fever is heredity. The early work of Cooke and Vander Veer, which has been amply confirmed by data of other investigators, has emphasized the importance of this observation. Precipitating factors are difficult to evaluate and their evaluation will continue difficult until the mechanism of allergic imbalance is more completely under-

* Presented at the 97th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1938.

stood. It is well to mention, however, the frequency that a history of tonsillectomy, adenoidectomy, or whooping cough, particularly in children, antedates but shortly the onset of symptoms. For this reason it has been suggested by some observers that elective surgery in the nose and throat, upon patients with known familial allergy, not be done during a period of active wind pollination.

The exciting factor is the inhalation of the specific pollen to which the patient is sensitive. To be an important cause of hay fever, a pollen must satisfy the following postulates enumerated by Thommen:[1]

1. *The pollen must contain an excitant of hay fever.* Under the requirements of this postulate, pine pollen, which fulfills many of the following postulates, can be eliminated as a causative agent because of absence of reactions to cutaneous tests.

2. *The pollen must be anemophilous, or wind borne, as regards its mode of pollination.* The requirements of this postulate eliminate many of the common garden flowers such as the goldenrod, rose, dandelion, etc. Because some of these flowers are closely related botanically to exciting plants, they should be kept from the patient's immediate environment. The pollen of these plants is too large and too sticky to be carried by the air.

3. *The pollen must be produced in sufficiently large quantities.*

4. *The pollen must be sufficiently buoyant to be carried considerable distances.*

5. *The plant producing the pollen must be widely and abundantly distributed.*

In Wisconsin there are three seasons in which pollens satisfying these postulates cause symptoms:

1. The spring season in which tree pollen causes hay fever. Hay fever of this type has a "short peak," affects a relatively small percentage of patients and occurs roughly from April through May.

2. The summer season in which hay fever is caused in the main by grasses and extends from June through July or early August.

3. The fall season in which hay fever is precipitated by the pollen of the fall weeds, particularly those in the ragweed family, and extends from mid-August until the coming of frost.

Diagnosis

The diagnosis of hay fever and asthma can usually be made from the history. Recurrent, seasonal attacks of nasal discharge, nasal block, lacrimation, sneezing and dyspnea are, of course, classical symptoms. The history in cases which are not so typical necessitates careful inquiry into many points. Symptoms which are sudden in onset, usually abrupt in disappearance and of longer duration than those in the usual attack of coryza, point to hay fever. The history of annual recurrence may be elicited. Appearances of other allergic manifestations in the patient, as well as in other members of the family, are extremely important. A detailed history of occupational and home exposure to various offending inhalants may give further leads as to contributory factors. The intelligent patient may note that symptoms are increased following the ingestion of certain foods.

As many patients present themselves for treatment prior to the onset of symptoms, physical signs may be lacking. When the patient is seen during the offending season, however, the conjunctiva are injected, the turbinates swollen, the mucous membrane has the characteristic bluish-white discoloration, and the presence of watery discharge and sibilant and sonorous rales gives objective evidence of allergic imbalance.

Laboratory examinations during the season of attack show a varying number of eosinophils in the nasal discharge and usually an eosinophilia.

When the clinical diagnosis is established, attention should be focused on the detection of offending allergens by means of skin tests, both scratch and intradermal. Tests should be made with the major pollen groups of the season of the patient's complaints; inhalant factors, including feathers, house

1. Thommen, A. A: Asthma and hay fever. Part III, p. 546. Baltimore, Md.: Charles C. Thomas, 1931.

dust, orris root, tobacco, silk, wool, seeds and epidermal proteins; the commoner foods in the diet of the patient and fruits and vegetables of the season under consideration. A complete examination should include tests with the commoner molds.

The skin tests not only give specific diagnostic information and confirmation of the impression gained from the history and physical examination, but also objective evidence of the degree of the patient's sensitivity. This is important as a guide to treatment.

The patient may give a history of difficulty only during a definite season of the year, but show evidence by skin test of positive reaction to other allergens with which he has daily contact by inhalation or ingestion throughout other seasons of the year. For instance, a positive reaction may be found to feathers in a patient who sleeps on feathers throughout the year but retains tolerance until a pollen factor is brought into his environment. Then, in spite of adequate pollen therapy, he is unable to retain his tolerance unless feathers are removed from contact with him during the pollen season. The same may be true of any other environmental inhalant.

A positive skin test means past, present or future sensitivity. A positive reaction should be coupled with the clinical history. A patient may give history of previous allergic imbalance caused by an allergen which no longer gives symptoms when inhaled or ingested. Tolerance has been established to this factor.

Treatment

The aim of treatment is to increase the patient's tolerance. Increased tolerance is generally not accomplished by the simple injection of pollen extract; it usually means as well control of certain offending inhalant and food factors. It is wise to eliminate positive reacting inhalants and foods from contact with the patient during the season of attack. This is particularly true of inhalants. Foods may be added one by one after the season has started, eliminating one which precipitates symptoms without other cause. In many patients it will be found that only one or two foods actually aggravate symptoms, although several give positive reactions.

After testing is completed, the results should be thoroughly discussed with the patient. His cooperation is essential, particularly in avoiding inhalant and food factors, and, as in the treatment of diabetic patients, he should be made aware of the need for cooperation. It may be well for the patient to read one of the books on allergic disorders written for the laity. He should be told in a specific manner how to prepare his bedroom to avoid feathers and dust. He should be instructed to avoid swimming, long drives in the country and golf during the season of his trouble. It is wise to advise patients against having cut flowers in the house during the season of symptoms.

In farmers and workers exposed to occupational allergens, physical protection may be offered by a simple mask to be worn when in the offending dust. The use of masks as a protection from pollen, however, has distinct disadvantages. The removal of the mask at meal time, particularly, will allow a sensitive patient to inhale enough pollen to cause symptoms during the inter-meal period. Of course, the mask is difficult to wear while sleeping.

In selecting pollen extracts, the physician should study the results of the patient's pollen tests and the type of pollen in the air in the locality at the time the patient has symptoms. Charts are available which show quantitative as well as qualitative pollen counts for various geographic locations. Individual extracts should be prepared on the basis of such study. Obviously, a patient sensitive to ragweed and any other fall pollen should be given an extract which is 80 to 90 per cent ragweed, for during the fall season about 90 per cent of the pollen in the air is of the ragweed family.

If the patient cannot avoid inhalants which are shown by the history and tests to cause symptoms or significant reactions, they should be injected as a separate extract. The prime offender in this class is house dust. The patient who is clinically sensitive to house dust is usually worse at night. His symptoms may not end with the coming of

frost, but may continue until the first of the year, due to the fact that unaided he cannot restore his tolerance until that time. It is wise in patients with this story and positive skin reactions to give dust extract along with pollen extract.

There are three methods in which treatment with pollen extract may be carried out; namely, the preseasonal, the co-seasonal and the perennial methods.

In the preseasonal method the patient's tolerance is gradually raised by giving increasing doses of pollen extract, the maximum dose being reached just before the season in which symptoms appear. The injections are given every four to seven days. The maximum dose varies greatly in individuals, ranging from 0.5 to 1 cc. of a 1:100 dilution. Some patients will tolerate no more than a tenth of this without severe local or constitutional reaction. These patients may obtain adequate protection from the smaller dose. As the season begins this dose is cut to two-thirds or three-fourths of the maximum and injections are continued throughout the season.

In co-seasonal treatment, the method used when the patient presents himself with symptoms, we must consider that he is already in a state of allergic imbalance due to inhalation of pollen and other allergens. Dosage therefore is minimal. The patient should be seen daily for several days and the minimal dose repeated or very gradually raised. This method of management offers far less comfort than the preseasonal method, but its initiation is worth while as a partial relief from symptoms may be expected.

Perennial treatment is probably the most satisfactory method of management. The injection of extracts is continued after the season of symptoms has passed, at a dosage close to the sustaining dose during the season. The patient is seen every two or four weeks throughout the winter, the intervals varying with the response to treatment. Before the next season of symptoms approaches he is seen oftener and the dosage raised until a maximum preseasonal dose is administered. This may be higher than a dose reached the previous year and results may be more satisfactory.

With all pollen therapy the possibility of reaction must be borne in mind. Reactions are usually caused by too rapid an increase in dosage, too long a period between injections, or injection of the material into a vein. It is well always to question the patient concerning the size of the previous local reaction, and to decrease dosage if this was too severe. Women patients are prone to have reactions just before or during a menstrual period. It is wise to have patients remain in the office for a period of fifteen to twenty minutes to control any reaction. If slight reactions occur with each injection, the patient may take an ephedrine capsule before coming to the office. This often will not only prevent reaction, but also allow increase in dosage.

The management of a constitutional reaction requires the application of a tourniquet to the arm above the site of injection, to retard entrance of the extract into the general circulation; the injection of epinephrine into the site of injection; and, if necessary, repeated injections of four to six minims of epinephrine at intervals until the discomfort subsides.

Mention of nonspecific measures to control allergic manifestations has been omitted purposely. The use of ephedrine and similar preparations is of distinct value in patients with symptoms. Oral hyposensitization or giving pollen extract by mouth is at present causing some interest. The general feeling is that this method has its greatest value in sections of the country where quantitative pollen counts are low. This certainly does not apply to Wisconsin.

The results of treatment in a series of cases should approach an effectiveness of 85 to 90 per cent. Failure to attain this result is usually due to insufficient dosage or failure to recognize nonpollen factors which upset the individual. In the fall season, an adequate dosage of ragweed extract is all-important and, as has been stated, because qualitative counts show us this pollen is by far the greatest offender, it should form the major portion of the pollen extract.

Significant Details in the Routine Health Examination of Children*

1. Examination of the Eye

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THE purpose of routine examination of the eyes of children is to separate those with obviously normal eyes from those with eyes which seem to need more detailed study or special attention.

Aside from the sick eye, which arrests attention by its appearance, there are two classes of eye defects which the physician should strive to discover in a health examination: (1) defective visual acuity, and (2) defective binocular coordination.

(1) *Defective visual acuity.*—To examine for defective vision, the subject is placed twenty feet from a well-illuminated Snellen chart. He is asked to read the letters with each eye separately, while the other eye is lightly covered with a card. If he reads the line designed as standard for twenty feet, his visual acuity is recorded at 20/20. If he reads the line designed, for example, as standard for fifty feet, his visual acuity is 20/50. Visual acuity of less than 20/20 in one or both eyes should be investigated; if it is less than 20/40 in either eye, such investigation should be strongly urged. The cause may be myopia, astigmatism, high hyperopia, corneal opacities, cataract, retinal lesions, amblyopia, or some other abnormality.

(2) *Defective binocular coordination.*—Normal binocular coordination exists when both eyes look at exactly the same point at the same time. Occasionally, normal eyes look crossed because of peculiarities in the lids. These need no treatment. When binocular coordination is imperfect, early treatment should be instituted. The end of the first year of life is not too early to start treatment. The longer treatment is delayed, the less becomes the probability of bringing about normal coordination. Normal binocular function can often be brought about by the use of glasses, orthoptic training, surgery, or a combination of two or three of these methods. Essentially all treatment consists of a re-education of the neuromuscular system. To secure early treatment, it is necessary, of course, to have an early diagnosis.

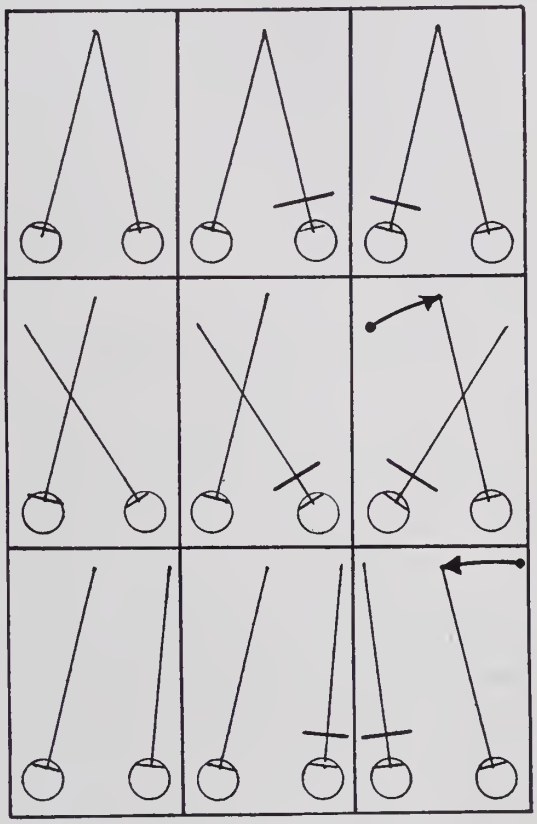

Fig. 1. Diagrammatic representation of steps in testing binocular coordination. Top: Orthophoria. Middle: Esotropia. Bottom: Exotropia.

The test is performed as follows: The subject is asked to look at a small spot—a flash lamp or a spot on a card—twenty feet away. The examiner then covers the right eye of the subject and observes the left eye. If the left eye does not move, it has been looking at the object of fixation before the right eye was covered. Therefore, either (1)

* Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

both eyes were fixing and binocular coordination is normal, or (2) the left eye was fixing both before and after covering, and the right deviates. Next both eyes are uncovered while the patient continues to look at the object. The left eye is then covered with the card. If the right eye now does not move, binocular coordination has been shown to be normal. If the right eye moves to fix the object when the left is covered, it must have been deviating while the left eye fixed.

From the direction in which the eye moves when its fellow eye is covered, one may determine whether a convergent or a divergent strabismus exists.

2. Examination of the Ear

By J. E. MULSOW, M. D.
Milwaukee

THE routine examination of the ear is divided into two parts: (1) the objective examination, and (2) the subjective examination.

The objective examination.—The objective examination consists of a general inspection of the auricle, the external auditory meatus, the cartilaginous portion of the external auditory canal, and the mastoid area. The physician should also determine whether the preauricular or postauricular glands are palpable; this may indicate an infection of the region drained by these glands. Congenital and traumatic deformities of the ear should be noted. Frequently one encounters various skin lesions, as eczema or a furuncle. If a furuncle is present any manipulation of the auricle is usually quite painful. The patient's history frequently denotes the diagnosis of furuncle.

The examination of the deeper portion of the ear canal and the drum membrane requires artificial illumination and necessitates the use of an ear speculum. The examiner should be very careful, in introducing the speculum, not to cause discomfort to the patient. Due to the fact that the external auditory canal is not a straight tube, some manipulation of the auricle is necessary before the introduction of the ear speculum. By lifting the auricle upward and pulling it backward, the cartilaginous portion of the ear canal is brought into a straight line with the bony portion of the canal, thus allowing a view of the bony canal and drum in most patients. However, in very young children, it may be necessary either to pull the auricle upward and backward or downward and backward to see the drum membrane.

Any obstruction of the canal, such as cerumen, pus or exfoliated epithelium, should be removed either by irrigation or with a cotton applicator. With a previous history of discharging ear, it is best to remove cerumen with a ring currette; if there is perforation of the drum membrane, irrigation may cause considerable discomfort.

The normal ear drum is a pearly gray color and about 8 mm. in diameter. It sets obliquely across the end of the external auditory canal; its thickness is about that of a piece of parchment paper. It presents several landmarks: There is the short process of the malleus—a small white spot—and, running downward and backward to a point slightly below the center of the drum, a white line which is the handle of the malleus. From the lower end of the handle of the malleus, extending forward and downward, is the so-called cone of light. The folds or ligaments of the membrane are seen on either side of the short process of the malleus, extending to the margins of the opening above the annulus tympanicus. Above this is the membrana flaccida (Shrapnell's membrane). In clinical description, the drum head is divided into four quadrants. A perforation is thus designated as located in the anterior inferior quadrant or post superior quadrant, etc.

The subjective examination.—The subjective examination consists of ascertaining the relative hearing power as compared to a normal ear and determining the location of any impairment which may be found.

The whispered voice is the best testing agent. A good tone is obtained if the examiner makes a forcible expiration and then uses the residual air for whispering. This tone can be heard by a normal ear at a distance of twenty feet. The patient sits with his eyes closed. The ear to be examined is directed toward the examiner; a pledget of cotton is placed in the other ear and held

firmly by the patient, or an assistant. The patient is instructed to repeat what he hears. Any numerals below a hundred are sufficient for this test. The examiner stands at a distance of twenty feet from the patient and approaches the patient until the voice is heard accurately. If the whispered voice is heard at twenty feet, the test is recorded as 20/20, the distance at which the normal ear should hear the sound. If the whispered voice is heard at ten feet, the test is recorded as 10/20. If the whispered voice is not heard, then the conversational voice should be used; in most examinations, both the whispered and conversational voice are required.

The watch test is not very accurate due to variations in the quality and quantity of sound produced. However, in this test, the watch is usually heard by a normal ear at a distance of forty inches, and the test is recorded as 40/40. If the watch is heard at a distance of twenty inches, the test is recorded as 20/40, etc., the first numeral designating the number of inches the watch is heard away from the ear.

Among the more scientific agents for testing the hearing are the tuning fork and the audiometer. Space does not permit a full consideration of their use here.

No ear examination is complete without an inspection of the nose and throat.

3. Examination of Nose and Throat

By LYMAN A. COPPS, M. D.
Marshfield

BEFORE examining the nose and throat an adequate history is quite essential for the reason that in these structures physical findings may vary much from day to day; they may appear quite normal at one time and present a much different appearance at another. It is important to know whether a child is a mouth breather constantly or periodically, and whether he has discharge from the nose, a feeling of dullness or headaches, and a predisposition to colds. Attacks of fever, with loss of appetite, fretfulness and irritability, are symptoms of acute tonsillitis in a young child.

The external appearance is first in importance. The physician should note the state of nutrition, weight and size as compared to age, the facial expression and the characteristics of the nose and mouth.

In examining the mouth, pharynx and nose, the examiner should look for sources of infection as well as those things which may structurally or mechanically interfere with normal development. Needless to say, one must first obtain the confidence of the patient, and this is particularly true when the pharynx is to be investigated.

To examine the nose, first elevate the tip with the thumb or finger; this shows the condition of the anterior part of the septum and the mucosa of the anterior nares, and exposes erosions, crusts, etc., in the vestibules. The interior of the nose can be seen with the otoscope, the condition of the septum and turbinates noted and pus, polyps, etc., discovered if present. The recognition of abnormalities in the mucosa is the most essential part of this examination for the pediatrician. A brilliant red, thickened mucous membrane in a child at the onset of fever indicates an acute respiratory infection. This may be the only physical finding noted. A pale, moist, edematous mucosa, especially if it has a bluish color, is found in nasal allergy. This condition may also be present in complete obstruction, caused by very large adenoids, nasopharyngeal polyps, atresia of the nasopharynx, etc. Pallor of the mucosa may indicate malnutrition or anemia, and erosions on the septum and lower turbinates are sometimes found in tuberculosis. Pure pus is evidence of sinusitis; mucopus may also be found in sinusitis or in obstruction. Unilateral pus with odor, crusts and ulceration about the anterior nares indicate a foreign body.

Trans-illumination may be done in a darkened room with the otoscope. By holding the light of the instrument close beneath the rim of the orbit, the frontal sinuses may be illuminated. The antrums may be illuminated by holding the light against the floor of the orbit, pressing the lower lid inward, and observing the light on the palate.

Obstruction to nasal breathing results in nasal and oral abnormalities which may have

far-reaching consequences. These are too often seen in adults who have narrow dental arches, high palates, deviated septa, and noses so narrow it is almost impossible to get proper ventilation and drainage of the sinuses by any means. It is important to recognize this condition at its onset and do those things which may rectify it. The condition of the teeth reflects the state of nutrition of the child. The tongue may be altered and Koplik spots may be seen in the cheeks or inside the lips.

In examining the tonsils and pharynx, have the patient open the mouth in a natural way without protruding the tongue, relax and breathe. Use the tongue depressor carefully, avoid too firm pressure on the tongue. Determine whether the tonsils are cryptic, phimosed, submerged, or adherent, and whether they may mechanically obstruct breathing. In older children one may express the tonsils by pressure on the anterior pillars with a large hook or postnasal mirror. The taking of a history is very important in determining how much harm tonsils may be causing in a child. The lingual tonsil may be seen by depressing the tongue more forcefully or with the aid of the laryngeal mirror.

The oral pharynx is seen if the tongue is depressed gently and the patient continues breathing. The mucosa may be moist or dry, there may be large or small patches of lymph tissue especially on the posterior-lateral walls, discharge from the posterior nares, or other abnormalities. Occasionally the lower borders of large pharyngeal adenoids may be seen just back of the soft palate.

In examining for adenoids or other nasopharyngeal conditions it is best to use the postnasal mirror. It should be inserted very gently between the depressed tongue and palate at one side of the uvula without touching anything if possible; the patient must be encouraged to continue breathing and relax. If this cannot be done, the examiner must resort to finger palpation. The examiner stands at the right of the patient, supports the head with his left hand and quickly inserts the right index finger behind the palate, removing it while the patient gags. With this one quick palpation the adenoids are felt and the finger may be inserted into the posterior nares to feel the lower turbinates or other structures.

It is difficult to examine the larynx by the mirror method in babies and little children so that in them the direct method must be used.

4. Orthopedic Examination

By WALTER P. BLOUNT, M. D.
Milwaukee

IN EXAMINING the child for abnormality of bone, joint and locomotor apparatus we should consider the first twelve years of life as constituting roughly four periods, and deal separately with (1) the infant under 1 year; (2) the very young child who cannot or will not talk but *will* walk; (3) the inaccurate informer of 3 to 6 years who is bashful, often uncooperative, and easily influenced into giving any answer the examiner may suggest; and (4) the school child who may be investigated much as an adult.

The infant is notoriously difficult to examine. The greatest information will usually come from simple observation of the squirming subject in the nude. The removal of diapers is important. Spasm, paralysis, disproportion, contracture, or deformity are usually detected on close scrutiny. Such deformities as wry neck, spina bifida, club foot, webbed or supernumerary digits are rarely missed. Slight asymmetry, especially hemihypertrophy or hemiatrophy, spinal curvature, and dislocation of the hip may not be noticed unless looked for specifically. A bilateral hip dislocation is particularly hard to detect by palpation. If the hips seem broad, high, or asymmetrical, an x-ray examination should be made.

When the child begins to walk, slight abnormalities of the locomotor apparatus are more evident. Limp is the arresting symptom and the study of the limp gives a great deal of information. The child may be taken from the mother and allowed to walk back to her. He may walk between two parents to a toy or a lollipop while the gait is studied. Experience enables one to identify a foot, knee, or hip limp. The gait of spinal disease is still different and calls for palpation, determination of joint motion, and measure-

ment of the length and circumference of the legs. X-ray and laboratory studies should be made as a final confirmation.

Mild flat foot is physiologic at 1 to 2 years of age. Foot strain demands attention. It occurs rather often in the weak or overweight child. It is a great deal more common than poliomyelitis and difficult to differentiate from the mild case of that disease. Tenderness of the inner border of the foot and particularly at the insertion of the anterior tibial tendon is almost pathognomonic of foot strain, while muscle tenderness is suggestive of poliomyelitis. In asking if pressure hurts, it is well to examine the part several times and, on the second testing, make the question negative, saying, "This doesn't hurt, does it?" Children who can talk are likely to answer any question in the affirmative. With the very young child one must rely entirely on the facial expression.

The older child is particularly subject to epiphyseal strain. At the knee and particularly at the hip we must differentiate between a traumatic or transient infectious cause and tuberculosis. The history, examination, and Mantoux test are important. The best test, however, is rest. If after a week in bed the symptoms are gone, the trouble was *not* early tuberculosis.

Don't *ever* tell a mother that a child will "outgrow" a deformity or disability unless you are certain of this outcome. Permanent harm may come to the child from prolonged neglect by trusting parents. Permanent harm may come to the doctor from a law suit.

5. General Considerations

By ROY M. GREENTHAL, M. D.
Milwaukee

A HEALTH examination has for its object the appraisal of the child, the detection of early or hidden deviations from normal, and the correction of such deviations if possible. The child comes to the physician presumably well, and when the examination is over the physician may assure the parents the child is in good health or he may suggest measures, either medical or surgical, that will improve health or prevent disease at some future time.

In general, a health examination requires more skill than does the diagnosis of disease in a sick child, as the signs and symptoms of conditions which may be present are not as plain. A health examination does not mean a short note on a card that the child is 2 pounds below normal weight, and that the tonsils are large and should be removed. Both statements may be true, yet the child's health may not be improved by adding 2 pounds in weight or by removing tonsils which, though large, are causing no symptoms. Judgment and experience are required in the appraisal of a child's health.

History-taking.—It is necessary to take a good history and to have some knowledge of the child's family before determining the significance of many details in the health examination. The detection and treatment of behavior problems in childhood are impossible without a full knowledge of the child's environment. Behavior defects are not manifested by physical signs as a general rule, but their correction is as vital to the child's health in many instances as the correction of physical defects.

Physical examination.—The physical examination must be careful and thorough. The nutritional status, as determined by height and weight tables, is at best a rough guide and even misleading at times. The examiner must supplement these measurements with clinical judgment and a knowledge of the child's parents. A thin, muscular, wiry child is often healthier than an overweight, flabby child. Obesity is becoming more of a problem than it was in the past and frequently requires corrective measures. In cases of obesity, glandular disorders—such as dysfunction of the thyroid or pituitary gland—may be present, but not as often as expected.

The evaluation of cardiac murmurs is sometimes difficult in health examinations. Some of them are due to congenital heart defects and often are of no great significance; others are functional; and still others are due to unsuspected rheumatic heart disease and are of serious import. Most diseases of the lungs cause illness and, therefore, are usually not found in the course of a health examination.

Laboratory tests.—A certain amount of simple laboratory work should be included in a health examination. The tuberculin test is of importance even in children who seem absolutely well. This test often gives information of great value to both the physician and the child and should be repeated annually. If the tuberculin test is positive, it should be followed by roentgen ray examination, particularly during the high school and college years.

Urinalysis is of value in detecting early nephritis, pyuria and diabetes. While it has been shown that albuminuria in childhood does not necessarily indicate nephritis, its discovery should lead to a more exhaustive study to prove or disprove its presence. Likewise, glycosuria may not be of serious import, but when it is discovered further study is indicated. A blood examination is of value in the detection of anemia; the color of the skin and mucous membranes is often an unreliable index as to the presence or absence of this disorder. Very rarely, a blood examination discloses some serious condition such as leukemia, in a child who does not appear ill.

In conclusion, I should like to emphasize the following facts: (1) A health examination is valuable and beneficial to the child and should be performed at least once a year.

(2) A health examination requires experience and skill; if done superficially, it is of little benefit to the patient.

(3) If the physical and laboratory findings are to be properly evaluated, the examination must be supplemented by a knowledge of the child's environment and parents.

Transvaginal X-Ray Treatment of Cervical Cancer

By ARTHUR W. ERSKINE, M. D.
Cedar Rapids, Ia.

Synopsis of Earlier Effort

The transvaginal attack on cervical cancer, as Merritt[1] said in 1921, "is by no means an innovation." Caldwell[2] designed and used an intravaginal tube in 1901 (fig. 1). Because filtered roentgen rays are safer and followed by less severe reactions, and because their distribution through the tissues is more nearly homogeneous, many radiologists have wished to use them instead of radium or radon for their destructive local effect upon cervical cancer. Shock proof tube stands and high capacity tubes have eliminated the danger of shock and reduced the tedium and discomfort of protracted treatments. It is difficult, however, to expose a sufficiently large field and, at the same time, protect the vulva and vagina from excessive irradiation. Opaque cylindrical specula give adequate protection but permit the exposure of only a small area. Merritt[3] exposes a large area through a speculum transparent to roentgen rays, using a focus-surface-distance of 50 cm. which is long enough to make the effective doses to the vaginal wall and the cervix about the same.

The Author's Technic

MY APPROACH to the problem of transvaginal x-ray treatment of cervical cancer has been described elsewhere.[4] The focus-surface-distance is shortened to 28 cm. and the vaginal wall retracted by an

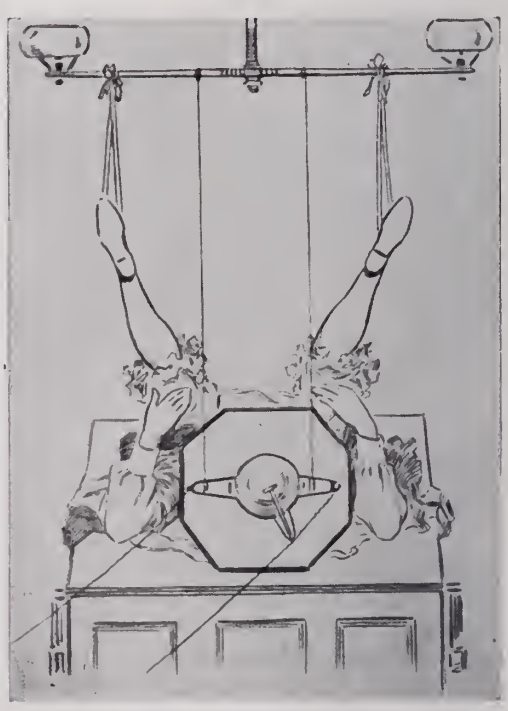

Fig. 1. An early method (1901) for applying roentgen therapy to a cancer of the uterus. (From C. W. Allen. Lea Brothers & Co., 1904.)

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* Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

eight-bladed expanding speculum (fig. 2). In the average patient, the straight, 9 cm. blades of the model shown in fig. 2 can be expanded to a diameter of 5 cm. (fig. 3). The diameter of the opening at the introitus is 26 mm. The cone of rays, therefore, lies just inside the blades and exposes a field 4.5 cm. in diameter. In order to expose a larger field two specula were constructed with the openings at the introitus enlarged to 31 mm. and 37 mm., respectively. These compromises with the Merritt technic increased the diameters of the fields to 5.5 cm. and 6.5 cm., and retained the rapidly expanding beam of the shorter focus-surface-distance.

Because the greatest expansion of the blades was at their inner ends, where the patients were least able to endure the discomfort of dilatation, it was found advisable to curve them and to substitute duralumin for steel (fig. 4). After inserting the speculum and expanding the blades, it is rigidly attached to the tube stand (fig. 5) by means

Fig. 2. Speculum with blades closed and obturator inserted.

Fig. 3. Blades expanded with wrench.

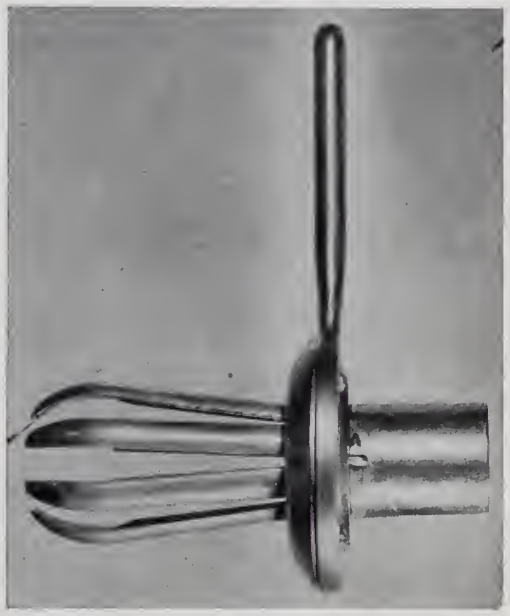

Fig. 4. Improved speculum with curved duralumin blades.

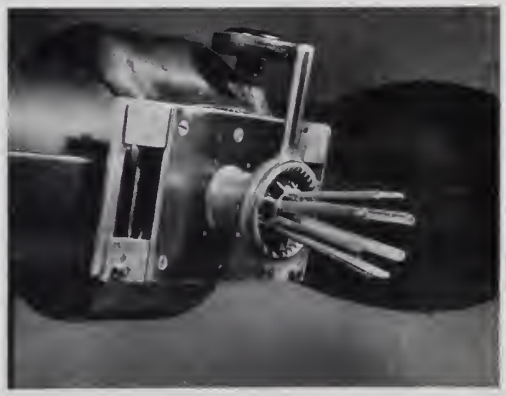

Fig. 5. Speculum attached to tube stand.

of male (fig. 6) and female (fig. 7) adapters. It was necessary, of course, to devise an attachment to the tube stand to which either the master cone or the plate holding the female adapter can be easily and quickly fitted.

Using 200 kv. and 20 ma. and an effective filter of 0.75 mm. copper, the intensity is 117 r/min. as measured in air at 28 cm. focus-surface-distance. It is increased by back-scatter to 131 r/min. with the small speculum, to 134 r/min. with the medium one, and to 138 r/min. with the large one. The excellent distribution obtained with these technics is shown in figs. 8, 9, and 10, which are constructed from measurements made in a water phantom, the blades of the speculum being covered with a rubber pouch and immersed in the water. It is interesting to compare these distributions with those obtained with the Chaoul technic and with radium. Mayneord,[5] in discussing rays from the Chaoul tube, says, "we may imitate fairly exactly the radium depth doses." This opinion seems to be supported by Arneson's[6] exact study of the distribution of the radiation from radium in colpostats in the lateral vaginal fornices, in combination with an intrauterine tandem. Assuming that fig. 11 represents the approximate distribution of radiation with good Chaoul technic, and also with good radium technic, a comparison with figs. 8, 9, and 10, shows that about 30 per cent of the surface dose in one case, and 60 to 70 per cent in the other, reaches a depth of 3 cm.

I am now giving three doses of 1170 r each, as measured in air, at weekly intervals at the start of the series of cross-fired treatments through external ports. Three similar doses are given at the end of the cross-fired series. The patient is then allowed to rest a month when a single dose of 1170 r is given. This dose is repeated one month later. Severe vaginitis and proctitis have been observed in only one patient.

The speculum cannot be used in the treatment of all patients with cancer of the cervix, but I have now used it enough to be convinced that the results are much better than when radium is used. Of nineteen pa-

Fig. 6. Blades expanded and male adapter attached.

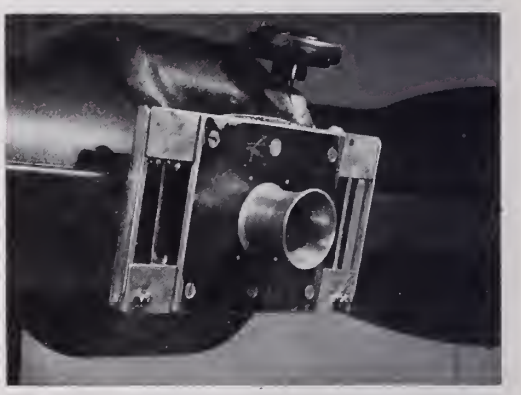

Fig. 7. Female adapter.

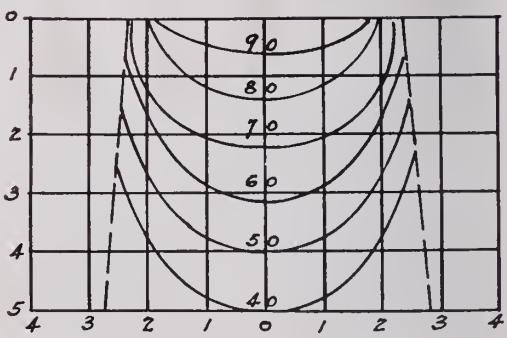

Fig. 8. Distribution of radiation with transvaginal technic (36 mm. opening).

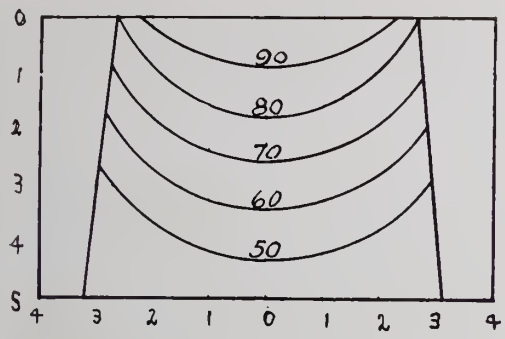

Fig. 9. Distribution of radiation with transvaginal technic (31 mm. opening).

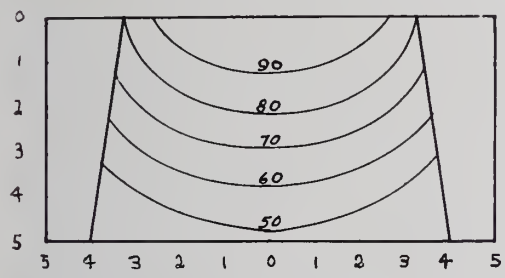

Fig. 10. Distribution of radiation with transvaginal technic (37 mm. opening).

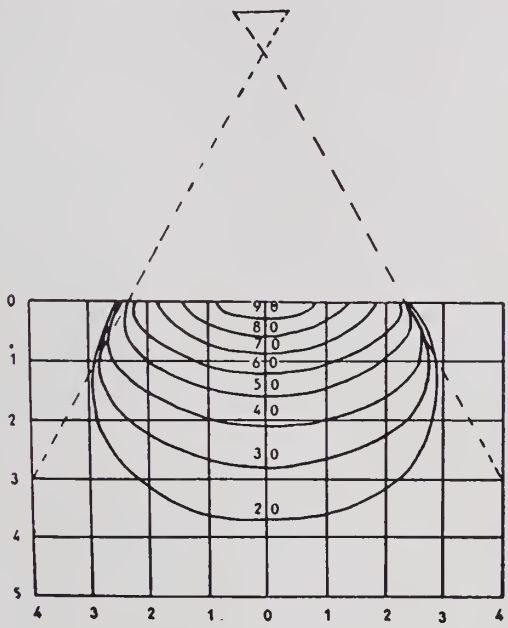

Fig. 11. Distribution of radiation with Chaoul's technic (Mayneord).

tients, the first one treated two years ago and the last one a year ago, fourteen are now symptom-free.

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AMERICAN BOARD OF INTERNAL MEDICINE, INC.

The American Board of Internal Medicine will conduct oral examinations just previous to the meeting of the American College of Physicians in Cleveland and just in advance of the meeting of the American Medical Association in New York City.

Applicants who have successfully passed the written examination and plan to take the oral examination in 1940, should advise the office of the secretary at least six weeks in advance of the date of the examination they desire to take.

The next written examination for 19 40 will be given on October 21, 1940. Applications for this examination must be fil ed in the Secretary's office by September 1, 1940.

Application forms may be obtained from Dr. William S. Middleton, secretary–treasurer, 1301 University Avenue, Madi son, Wisconsin.

Otolaryngologic Aspects of Blood Dyscrasias*

By W. E. GROVE, M. D.
Milwaukee

IN THIS day of intense specialization in medicine one must learn to correlate and interrelate one's own specialty with other fields of medicine. This is of particular importance in a study of the blood dyscrasias. In so many of these diseases the initial or early symptoms fall within the domain of the otolaryngologist that it behooves him to have a thorough blood examination made in most of his patients.

The blood dyscrasias under consideration may be roughly divided into four general groups: the anemias, the hyperplastic diseases, the aplastic diseases and the hemorrhagic diseases. Among the anemias one must consider primary or pernicious anemia and also the secondary anemias of whatever cause. The hyperplastic diseases are those in which the blood forming organs are stimulated to increased activity and a hyperplasia of particular parent blood cells takes place. Among these diseases are the acute and chronic leukemias — lymphatic and myelogenous, acute monocytic leukemia, acute infectious mononucleosis, and polycythemia vera or Gaucher's disease. The aplastic blood dyscrasias, in which the hemopoietic system is depressed, are the conditions known as agranulocytosis or granulocytopenia, Frank's aleukemic leukemia and aplastic anemia. Among the hemorrhagic diseases are hemophilia and purpura hemorrhagica or Werlhof's disease.

The particular pathologic lesions of the blood dyscrasias which appear in the nose, throat and ear and which should crystallize the attention of the otolaryngologist are mucous membrane changes consisting of hemorrhage, infiltration, ulceration, necrosis and gangrene. The spontaneous hemorrhage which occurs in these conditions has always intrigued me. Is it a primary lesion or is it preceded by infiltration, the death of tissue and ulceration? It has never seemed to me that the reduction in platelets alone was a sufficient and adequate cause for the hemorrhage. Some other factor must operate to increase the permeability of the capillary wall. What that unknown factor is I do not know. Winternitz[1] of the pathological department of the Yale Medical School, who has done considerable work on the pathology of the blood vessel wall is working on this problem at present and hopes to throw some light on it in the near future.

The relation of throat infections to certain of the blood dyscrasias is still obscure. The older clinicians regarded the throat infection as the etiologic cause of the blood disease and while this may be true in certain cases it is a fact that there are primary blood diseases which produce lesions in the mouth and throat and, as Shea[2] says, "it is difficult to separate the border line cases."

The Anemias

In pernicious anemia sore tongue occurs in about 50 per cent of the cases. This is the so-called Hunter tongue or glossitis. In the beginning the tongue appears to be "beefy" red in patches involving the whole dorsum. Small blister-like elevations appear on the margins or the top of the tongue which break down into shallow painful ulcers. This painful condition may remain for a few days and then disappear only to recur later. After a number of these attacks the surface epithelium atrophies, the papillae disappear and the smooth glazed tongue of the declared condition remains.

In the secondary anemias the mucous membranes of nose and throat are characterized by palor and at times by hemorrhages. If the anemia is severe enough superficial ulcerations will appear due to the deficient blood supply. In all forms of primary and secondary anemia ear symptoms are encountered. This is particularly true of pernicious anemia. These symptoms

* Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

are tinnitus, vertigo and more rarely disturbances of hearing. The symptoms are probably due to an anemia of the labyrinth. When deafness is present it is due either to anemia in Corti's organ or to degenerative changes in the neuroepithelium caused by nutritional disorders.

Hyperplastic Diseases

Acute leukemia.—The acute leukemias, the lymphatic and the myelogenous, are rapidly progressive and fatal diseases of unknown etiology in which stimulation and hyperplasia of the bone marrow take place. Since the papers of Clough[3] and of Forkner[4] were published one must add a third variety, the acute monocytic leukemia, characterized by a predominance in the blood of the monocyte, a cell derived, like the histiocyte, from the reticulo-endothelial system. A sharp differentiation of the three types is not always possible because of difficulties in the staining reactions and because of atypical cases in which all three types of cells occur. Any profound disturbance of one portion of the hemopoietic system interferes with and perverts other parts as well.

The acute leukemias are characterized by a sudden onset with fever, marked prostration, a tendency to necrotic and gangrenous processes in the mouth and throat, hemorrhages from the mucous membranes of the nose and the enlargement of lymph glands and other lymphoid structures. Intractable hemorrhages from the mucous membranes of nose and mouth may be the first symptoms. In other cases cough and dyspnea from enlargement of the thymus and mediastinal lymph glands, sore mouth with swollen and bleeding gums, ulceration of the tonsils or sore throat may be the early symptoms. It is Forkner's[4] opinion that diffuse marked swelling of the mucous membranes, particularly of the gingivae, associated with bleeding, ulceration and necrosis is especially characteristic of acute monocytic leukemia and usually absent in the acute leukemias of myelogenous or lymphatic types. He says, "in association with these lesions of the mucous membranes there usually occurs what appears to be a diffuse cellulitis about the lesions causing swelling and pain with signs of acute inflammation extending into the deeper tissues of the face." Inasmuch as these sore, swollen, bleeding and ulcerated gums are so frequently the first symptoms of the disease the patients frequently consult their dentists. Spirilla and fusiform bacilli are so often encountered at this stage that a mistaken diagnosis of Vincent's angina is frequently made.

The onset of acute leukemia may suggest the commencement of a large number of conditions such as tonsillitis, quinsy, diphtheria, Vincent's angina, agranulocytosis, typhoid fever, septicemia from any cause and purpura hemorrhagica. In a case which recently came to my attention the initial symptom of an acute lymphatic leukemia was a facial paralysis which persisted until death. The blood count early in the disease may be misleading for the white count may not be high. It may even be normal or subnormal.

Chronic leukemia.—While the acute leukemias are primarily diseases of youth, the chronic leukemias—myelogenous and lymphatic—can occur at any age. The hemorrhages, ulceration and gangrenous necroses of the mucous membranes seen in the acute types are also observed in these conditions but usually later in the course. Marked glandular hypertrophy takes place in the lymphatic variety. Cases of chronic lymphatic leukemia without adenopathy have been reported but are exceedingly rare. Enlargement of the tonsils may take place relatively early and lead to disastrous results from incautious removal. The changes in the tonsils in leukemia have been adequately described by Brunner and Fischer.[5] On the other hand, enlargement of superficial lymph glands rarely occurs in chronic myelogenous leukemia.

Most interesting to the otologist are the ear lesions which occur in the chronic leukemias. These have been assembled by Politzer,[6] Fraser[7] and others. Hemorrhage is the main factor in the production of leukemic ear symptoms. Hemorrhages can take place in all the divisions of the ear and even into the cochlear and facial nerves. These are often combined with leukemic infiltrations. The external ear is least frequently involved

but hemorrhages and ulcerations have occasionally been observed here.

In the middle ear hemorrhages, combined with leukemic infiltration, may occur and are frequently complicated by infectious changes. These same changes have been observed in the mucous membrane of the Eustachian tube. When hemorrhage takes place into the middle ear a hemotympanum is produced and the drum takes on a bluish discoloration with bulging.

The inner ear is the part most frequently involved by leukemic changes, and of these hemorrhage plays a more important role than infiltration. In severe hemorrhage all the hollow spaces of the internal ear may be filled with blood. By compression alterations of form or partial obliteration of the labyrinth take place followed by degenerative changes in the neuroepithelium, especially Corti's organ. After organization of the blood effusion and the lymphatic infiltration, the endolymph and perilymph spaces fill with connective tissue which may ossify, producing otitis interna ossificans and causing total ablation of function.

The clinical picture of the leukemic ear depends upon the region involved. The most marked symptoms appear when the labyrinth is involved. Small circumscribed hemorrhages may absorb without producing any symptoms. If the hemorrhage into the labyrinth is large and diffuse the classical symptoms of the Ménière's syndrome appear. Sudden deafness may be the first symptom of a chronic leukemia. When a large hemorrhage involves both portions of the inner ear the deafness is accompanied by tinnitus and violent vertigo. Consequently, the sudden appearance of Ménière's syndrome in an otherwise healthy patient absolutely demands a hemogram. Deafness may also occur because of a gradual infiltration of the cochlea or the cochlear nerve and this infiltration occurs quite commonly in chronic myelogenous leukemia.

Infectious mononucleosis.—Infectious mononucleosis is "an acute infection, benign in nature and of unknown etiology, characterized clinically by irregular fever, sore throat, swelling of the lymph glands, notably the cervical, and enlargement of the spleen, as well as an absolute and relative lymphocytosis and the presence in the blood of abnormal, though chiefly mature, lymphocytes."[8] It occurs in sporadic and epidemic form.

The etiology is unknown. No age is immune but it rarely occurs after 40 years of age. The epidemic form is more common in children while the sporadic form occurs in older children and young adults. Staphylococci, streptococci, the spirilla and fusiform bacilli of Vincent's angina, the bacillus monocytogenous hominis, and more lately the Listerellae have been thought to be the etiologic agents by various observers. It is possible that it may be a virus disease.

Tidy[9] distinguished three types of cases: (1) the glandular or Pfeiffer's type; (2) the anginose type or monocytic angina; and (3) the febrile type.

The glandular form occurs chiefly in children. Adenopathy soon becomes pronounced, particularly in the glands of the posterior cervical chain, but these discrete, moderately tender glands are rarely symmetrical.

In the anginose type the main symptoms are those involving the throat. The clinical picture may be confused with diphtheria inasmuch as a membrane develops on or near the tonsils. Some cases present diffuse swellings simulating a peritonsillar abscess. In one of my recent patients, a lad of 22 years, whose tonsils had been removed, every lymphoid follicle in the pharynx became swollen and tipped by a small ulcer. These ulcers also involved the lingual tonsils.

In adults the febrile type is most common. The onset is sudden with malaise, fever and headache. This headache may be so severe as to suggest meningitis. In fact, meningitic irritation may occur in this condition for in five patients with infectious mononucleosis Schmidt and Nyfeldt[10] found an increased cell count in the spinal fluid but usually late in the course of the disease when the fever was subsiding. They also obtained a pure culture of Listerellae from the spinal fluid in all five patients.

Infectious mononucleosis may be mistaken for influenza, grippe, typhoid fever, German measles, simple pharyngitis, tonsillitis, quinsy, scarlet fever, diphtheria, Vincent's

angina, Hodgkin's disease, tuberculous adenitis, syphilis, acute leukemia or even agranulocytosis. The diagnosis, however, can be definitely established by the blood picture, showing a relative and an absolute increase in rather large mononuclear cells, nongranular by the oxidase stain, by the presence of heterophile antibodies in the blood and by the benign course. Since Paul and Bunnell[11] have shown that heterophile antibodies, in the form of sheep cell agglutinins in high dilutions, are rarely found in human blood in high titres, except after the administration of serum, their presence in a suspected sporadic case makes the diagnosis fairly certain. They have not thus far been studied in the epidemic form.

Polycythemia vera.—In polycythemia vera or Gaucher's disease the tongue is increased in size. Its color is "beefy" red and the hypertrophied papillae give its surface a granular appearance. Furrows and fissures are frequently noted and the patients state that they can suck blood from the tongue.

Aplastic Diseases

Granulocytopenia, occurring in an acute fulminating or an insidious chronic form, may begin with a sore throat of sudden onset or, occasionally, a long-continued sore throat. As the otolaryngologist sees many sore throats of varying etiology it behooves him, as well as the clinician in general, to have a hemogram made in every case of sore throat. The condition is clinically characterized by (1) a predominance in the female sex, (2) an acute onset as a severe infectious condition with rapidly developing prostration, high fever and a toxic appearance out of all proportion to the meagre physical signs; (3) local lesions in the form of ulceronecrotic areas, most marked on the buccopharyngeal mucosa, although they may occur on any of the mucosae of the body; and (4) a marked leukopenia.[12]

The local lesion in the oropharynx begins with a hemorrhagic, cyanotic area which becomes sharply demarcated, necrotic and soon ulcerates. Whether the angina is the cause or the effect of the derangement of the bone marrow is not yet certain except in those cases known to have been caused by susceptibility to certain drugs.

This condition must be differentiated from certain other ulcerative lesions of the oropharynx such as acute streptococcic sore throat, Vincent's angina, follicular tonsillitis, diphtheria and tertiary syphilis. A characteristic of the granulocytopenic ulcer is the presence of a well demarcated margin surrounded by a noninflammatory zone and associated with intense edema of the surrounding soft parts, so intense that breathing and swallowing may become difficult.

A low white count is also exhibited in influenza, typhoid fever, some of the exanthemata and at times in severe sepsis.

Confusion sometimes arises in differentiating granulocytopenia from aplastic anemia and from aleukemic leukemia. It may at times be utterly impossible to differentiate it from the aleukemic phase of a leukemia except by a study of the bone marrow, the subsequent course and the marked enlargement of spleen and lymph glands. In aplastic anemia all portions of the blood elements show a characteristic depression.

Hemorrhagic Diseases

The hemorrhagic diseases under consideration are hemophilia and purpura hemorrhagica. Their main symptom, in so far as the interest of the otolaryngologist is concerned, is hemorrhage into or from the mucous membranes of the nose, throat and ear.

In purpura hemorrhagica, also known as thrombocytopenic purpura and as Werlhof's disease, the most frequent site of bleeding is the nose while bleeding from the gums and mouth comes next in order. These hemorrhages are associated with a reduced platelet count, a prolonged bleeding time, and a normal coagulation time, although there is a nonretractile clot. The platelet deficiency seems to be the most important factor for the causation of the condition and according to Minot a normal bleeding time in this condition occurs only when the platelet count it above 60,000. However, in addition to this platelet deficiency other factors must be present. Some sort of injury to the vessel wall is considered to be essential for the production of hemorrhage. It has been sug-

gested that the platelets have some sort of a hormone action on the capillaries and when this is absent bleeding occurs. Others believe that the endothelial cells lining the capillaries lose their adhesive qualities and that this hinders their closure by the blood clot.

In hemophilia the symptoms depend upon an impaired coagulability in the males. As in purpura the most frequent sites of hemorrhage are the nose, the mouth and the gums. In this condition the platelets are normal in number and morphology but their behavior is abnormal.

Conclusions

In conclusion let me say that no remarks on therapy have been made for such therapy as is possible in these conditions lies in the field of the internist, but I believe I have shown that the otolaryngologist must be ever on the alert for the early recognition of the blood dyscrasias and that he should make more frequent use of the hemogram.

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Surgical Treatment of Prostatic Obstruction

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THE surgical extirpation of the various organs of the body usually finds a unanimity of opinion as to the proper method of approach. This simplicity of exposure does not exist in the field of prostatic surgery, in which an operation that may be done by one of three incisions—suprapubic, perineal or transurethral—will have champions for each method. Their viewpoints will be colored by the training they have received and by their ability to accomplish good results by one particular method.

Suprapubic Prostatectomy

Following the work of Goodfellow, Fuller and Freyer, and others, the suprapubic operation became the most widely used method up to the past few years. Its early acceptance and long period of popularity are not hard to understand. The technic was almost foolproof and involved a minimum of anatomical knowledge; hence, it was easy to learn. Hemorrhage was quite adequately controlled by pack or bag.

Refinements in technic were then directed at reducing the period of drainage by reconstructing the prostatic bed and primary closure of the bladder; this never became generally popular, however, because of the technical difficulties involved and the special instruments required. Nevertheless, suprapubic prostatectomy remains the operation of choice with a few excellent surgeons and with those whose training has not included transurethral and perineal prostatectomy. Even in the hands of experienced men the mortality in suprapubic prostatectomy has never been as low as that in transurethral and perineal prostatectomy. An interesting observation in this connection is that the men who now most ardently support trans-

* From the department of urology, University of Wisconsin Medical School. Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

urethral resection formerly did the suprapubic operation, whereas few men who have used the perineal operation have given it up for resection. The frequency of surgical shock and abdominal distention, and the long period of drainage and hospitalization brought about a willingness to discard the operation. A great portion of the blame for the dismal record in the treatment of prostatic cancer can be placed upon the suprapubic operation which not only could not cure, but could not even make the last days of the cancer patient comfortable.

In the last two and one-half years suprapubic prostatectomy was done twelve times at the Wisconsin General Hospital. The choice of method in these cases was determined for the reasons that some were admitted with a suprapubic tube in place, no instrument could be introduced in the urethra, other lesions of the bladder such as a diverticulum existed, or the prostate was of the large intravesical type. In all cases hemorrhage was controlled by the use of a Pilcher bag.

TABLE 1.—*Data on 12 Patients Subjected to Suprapubic Prostatectomy*

Average age	68.3 years
Average total hospital days	44.4
Average postoperative days	26.8
Mortality	8.3%

In none of the patients was reconstruction of the prostatic urethra and primary closure of the bladder attempted. All showed varying degrees of shock and abdominal distention following operation.

Perineal Prostatectomy

More than thirty years ago Hugh Young developed his perineal method of prostatectomy. It is an operation based on sound anatomical principles and requires an exactitude of execution which has caused it to be accepted by few, other than pupils of Young. Because of the perineal incision, surgical shock and abdominal distention are exceedingly rare. Following the operation the patient rarely evidences any signs of a major surgical procedure either early or late. The mortality rate is uniformly lower than in the suprapubic operation but the functional results may be embarrassing both to the patient and surgeon if the rectum or urethral sphincter are injured. It is an operation which cannot be mastered piecemeal as can the transurethral operation. Once begun it must be finished. However, the technical difficulties and dangers to the rectum and sphincter have been exaggerated, as with attention to detail it is a simple operation to master. But its greatest value lies in the fact that it is the only operation by which it is possible to make an attempt at curing early cancer of the prostate.

At the Wisconsin General Hospital perineal prostatectomy was done twenty-two times in two and one-half years. This method was uniformly selected because the glands were large or because cancer was diagnosed or suspected. In two patients radical perineal prostatectomy for cancer was done. The average weight of the glands was 72 grams. That we were operating on rather large glands is shown by the fact that the average weight of the hypertrophied prostate is 45 grams.

TABLE 2.—*Data on 22 Patients Subjected to Perineal Prostatectomy*

Average age (Youngest 57; oldest 83)	67.3 years
Average total hospital days (3 stayed 60 days, because of pneumonia, suprapubic fistula, periurethral abscess)	36
Average postoperative days (7 stayed less than 20 days; shortest stay was 12 days)	23
Mortality	4.5%

Surgical shock or abdominal distention did not occur in any of the patients. One patient died three days postoperatively from a cardio-circulatory accident. In all cases the prostatic capsule was closed without drains or packs and the bladder was drained by a Foley urethral bag catheter. Hemorrhage was controlled by suture of the bladder neck to the prostatic capsule and in only a few cases was it necessary to put tension on the Foley bag. In 75 per cent the perineal wound was healed and dry in sixteen days.

Transurethral Prostatic Resection

With the perfection of instruments that could remove tissue under vision with adequate control of hemorrhage, transurethral

prostatic resection became at once an exceedingly popular operation. The continued efforts at simplification of prostatectomy by the punch method, and by primary closure after open operation, had effectively prepared the way for its use in "poor risk" patients. Another factor which enhanced its popularity was that it required a minimum of surgical skill and could be learned piecemeal. The beginner could start on the small glands and work up to the larger, and further he could stop at any time hemorrhage was under control and bring his patient back at another time and finish the job.

Even with the gradual method of learning to do the operation, it was soon realized that it was not a minor office procedure but a major surgical procedure that demanded careful preoperative and postoperative care. Even then complications could and did occur such as strictures, hemorrhage, incontinence, urinary sepsis and rupture of the bladder. These errors in technic do not necessarily condemn the operation but only indicate the need for caution in its execution. The control of infection is difficult because most of these prostates are infected at the start. Failure to remove all prostatic tissue makes healing slow and infection likely, because of the lack of the blood supply in the remaining urethral tissue. Morson has stated that after primary closure healing is not complete for from three to six months, and after resection the time is but little shorter.

Transurethral resection of the prostate was done on 257 patients at the Wisconsin General Hospital in the last two and one-half years. This number represents 88 per cent of the total. As a group these patients include both the best and the poorest risks.

TABLE 3.—*Data on 257 Patients Subjected to Transurethral Prostatic Resection*

Average age	67.6 years
Average total hospital days	25.6
Average postoperative days	12.5
Mortality	3.9%

The most frequent complication was that of infection and was more obviously present in the patients who had markedly infected glands and urine, and in those in whom practically all the prostatic tissue was not removed. It has become increasingly apparent that simply cutting a channel is not sufficient to insure a satisfactory result. The work of Flocks on the blood supply of the prostate has shown this to be true. In all cases immediate hemorrhage was easily controlled but in three patients secondary hemorrhage occurred at five, nine and fourteen days. In two evacuation of the clots and an indwelling catheter were sufficient, and in one the bleeding point was fulgurated. In 11 per cent the operation had to be done more than once. This was carried out in five to seven days following the first operation. The one factor in our experience which I would stress is the time these patients are kept on the operating table. Forty-five minutes has been the maximum time and since adopting this plan morbidity and mortality have been improved. When one is training younger men to do the operation this point is particularly important.

Choice of Technic

If a surgeon can properly do a transurethral prostatic resection need he know more about prostatic surgery? As all surgeons are fundamentally teachers of their younger associates, I think this question deserves a little thought. In a teaching institution where both graduate and undergraduate instruction is given, it is desirable to avoid an extreme viewpoint. A fairly uniform agreement exists that transurethral resection is the ideal operation for median bar, extensive carcinoma and most of the cases of benign hyperplasia. The point of contention then includes only cases of early carcinoma and of very large, adenomatous, hyperplasia —about 10 per cent of all the cases. For this group a surgeon should have sufficient training to do an operation other than transurethral resection.

Why stress this 10 per cent of patients in the treatment of prostatic obstruction? The answer lies in the fact that it is here we find the greatest potential morbidity and mortality in prostatic surgery. A transurethral resection becomes increasingly difficult in the larger hypertrophied glands, thereby making the incidence of complications

higher, particularly if the operation has to be done more than once. And, last but not least, an operation that slices out part of a cancer can never be regarded as an effort at cure. Everyone agrees that resection is the best palliation in cancer of the prostate where the growth has become extensive. However, the fact that early cancer of the prostate is so rarely seen is no justification for completely abandoning all efforts to improve our results.

Prostatic Cancer

Young, Smith, Hinman and others have repeatedly shown that the radical perineal prostatectomy can cure prostatic cancer. A fatalistic attitude of palliation and an unwillingness to face and master a difficult operation have given us a dismal record in the treatment of the most common cancer occurring in men past 60 years of age. It is true that most of these patients have passed the operable stage when first seen but a concerted effort at earlier recognition and exposure of the suspicious cases perineally will save the lives of many men.

When we consider the fact that cancer of the prostate occurs in from 10 to 30 per cent of patients with prostatic obstruction, and that 75 per cent of these cancers occur in the posterior lobe, we can see the value of a careful rectal examination in these elderly patients. In this age of cancer-consciousness, cancer of the prostate must be included in the program of public information. The public should be advised of its frequency, early detection and diagnosis by the clinician, and real efforts at cure by the surgeon.

A study of any series of cases of cancer of the prostate leaves little of which we can be proud. The problem of treatment involves both the relief of urinary obstruction and the eradication of the cancer. Unfortunately, obstruction may not develop until the cancer has passed the operable stage.

A follow-up study.—I was able to follow up 105 patients with cancer of the prostate who were admitted to the hospital more than two years ago. This information was secured by writing to the patient's local physician, his relatives, or to him. In addition to this, the Bureau of Vital Statistics was consulted and in three cases the patients were examined in the hospital. All the patients were found to be dead except seven, five of whom were in good health.

TABLE 4.—*Data on Course of 105 Patients With Prostatic Cancer*

	Number of Patients	Hospital Mortality %	12 Months Mortality %
No x-ray or other treatment for pain	20	5.0	95.0
Suprapubic prostatectomy	9	0	55.5
Radical perineal prostatectomy	4	0	25.0
Transurethral resection	55	4.9	54.5
Cystostomy for drainage	17	31.2	87.5

Forty-one or 38 per cent had definite evidence of remote metastases on admission. Of the seven patients who were living two were in very bad condition but had lived fifty-seven and thirty-six months following resection. Two more of the fifty-five who had transurethral resection were living and well fifty-six and fifty-four months later. In both of these patients only an isolated area of early cancer change was found. The diagnosis was not suspected before operation. Of the four patients who had radical perineal prostatectomy three were living and well twenty-seven, fifty-seven and fifty-eight months later. One died twelve months after his operation. All these patients had at least twelve x-ray treatments following operation. In this series, then, we have possibly cured only 4.7 per cent of the patients; three by intention and two by happenstance.

The average age of the group was 69 years. The age distribution by decades was as follows:

Decade Years	Number of Patients
50	11
60	40
70	48
80	6
	105

By consulting the American experience tables of mortality we can see that this group of individuals was deprived of approximately 697 years of life by cancer.

Conclusions

1. Suprapubic prostatectomy is a simple operation to master but carries a high mortality rate. It has no place in the treatment of cancer.

2. Perineal prostatectomy is more difficult to master but gives a low mortality rate. It is the only operation by which cancer of the prostate may be successfully treated.

3. Transurethral resection of the prostate can be learned gradually by starting on small glands. The mortality rate may be lower than any other method. Complications and accidents increase as the larger glands are resected. It is the best palliation in treating extensive cancer.

4. In the training of surgeons it is not sufficient to teach the transurethral method alone. In from 5 to 10 per cent of cases other methods of surgical treatment will be required.

Sectional Meeting, American College of Surgeons

Detroit, April 1-2-3

THE Wisconsin State Executive Committee of the American College of Surgeons announces a sectional meeting of the College in Detroit, Michigan, April 1, 2 and 3, with headquarters at the Statler Hotel. The committee, which is composed of Drs. Erwin R. Schmidt (chairman), Madison; Curtis A. Evans (secretary), Milwaukee; F. Gregory Connell, Oshkosh; and S. E. Gavin, Fond du Lac, states that Illinois, Indiana, Michigan, Ohio and Wisconsin, and the province of Ontario will participate in the event.

Distinguished surgeons from various parts of the country will address the sessions. Among them will be the president of the College, Dr. George P. Muller of Philadelphia, and the vice chairman of the Board of Regents, Dr. Arthur W. Allen of Boston.

The twenty-seven approved hospitals of Detroit provide excellent facilities for the series of operative and nonoperative clinics in general surgery and the surgical specialties which will be held during the first two days of the meeting. The third day will be Ann Arbor Day; buses will leave the hotel in Detroit in the morning for Ann Arbor, and clinics, demonstrations, and conferences will be held at the University Hospital there from 9:30 until noon. A luncheon for Fellows and guests will follow at the Michigan League Ball Room. In the afternoon in the main amphitheater of the Horace H. Rackham School of Graduate Studies, a conference will be held on general surgical and allied subjects.

In addition to the clinics, clinical demonstrations and conferences at the hospitals, scientific sessions, conferences, and panel discussions will be held at the headquarters hotel.

Hospital conferences will also be held throughout the three days of the meeting. These will cover a wide variety of subjects of interest to hospital personnel. There will be formal meetings, round table and panel discussions, a special program of medical motion pictures on hospital topics, and special demonstrations of procedures in the local hospitals. Two breakfast conferences will be held for hospital representatives on Tuesday and Wednesday mornings which will present exceptional opportunity for informal discussion of hospital problems.

At the headquarters hotel there will be educational and scientific exhibits and showing of motion pictures portraying surgical and hospital procedures. Daily bulletins will be issued listing the various sessions, conferences, clinics, and other events of each day.

The meeting will close with a session in the Masonic Temple, open to the public, on the subject of "Conservation of Health."

The medical profession at large, as well as hospital trustees, superintendents, pathologists, dietitians, and other hospital executive personnel, will find much to interest them in the varied program at this meeting. Members of the State Medical Society are most cordially invited to attend. There will be no registration charge.

Comments on Treatment

EDITORS
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Adrenal Insufficiency

With the steady improvement in available adrenal preparations, it has become possible to treat adrenal insufficiency with increasing effectiveness. There is every indication that this progress will continue as the chemistry of the adrenal cortex and the cortical hormones becomes better understood.

The problem of diagnosis of adrenal insufficiency has also received considerable recent attention so that it is now possible to establish the existence of this condition by means of laboratory methods. The easiest technic is probably that of Cutler, Power and Wilder (J.A.M.A. *111:* 117, 1938), in which the patient is carefully placed upon a period of restricted sodium chloride intake, with extra potassium added to the diet. During a definite test period the urinary output of chloride is measured, and the diagnosis depends upon finding an excretory level distinctly higher than normal. Not only does this technic make possible a degree of assurance and precision previously impossible, but determination of urinary chloride is so simple that it is within reach of almost any clinical laboratory. The well known triad of manifestations—weight loss, pigmentation and hypotension—are still reliable criteria for advanced cases. The laboratory procedures are of particular value in studying mild or border line cases.

The treatment of Addisonian crisis must always be physiological sodium chloride and glucose, usually 5 per cent, by venoclysis. Cortical extract should be added directly to the infusion fluid, or given separately by intravenous or subcutaneous route, or both, in amounts determined by the gravity of the situation and the promptness of response. It is not unusual that a patient in serious crisis will need 75 to 100 cc. of the usual cortical extract in addition to the other parenteral fluids.

The extreme sensitivity of adrenal–insufficient patients to insulin should be mentioned. It is always dangerous to give insulin to such an individual because of the hypoglycemia which may result. It may even be dangerous to give glucose intravenously, unless cortin is given also.

Adrenal extracts to be recommended are Eschatin of Parke, Davis & Company, adrenal cortical extract of either the Upjohn or Wilson Laboratories. Each preparation assays at 4 rat units per cc.

Maintenance therapy consists of subcutaneous adrenal extracts, usually not over 10 to 12 cc. daily in divided doses with 10 to 12 grams of extra added sodium chloride, given in capsules, as tablets, or as 0.9 per cent sodium chloride orally. Sodium citrate may replace some of this salt and has the advantage of relieving the necessity for renal excretion of the chloride ion. Oral therapy with potent preparations (Cortalex–Upjohn) (Cortisorbate–Shieffelen) has much to recommend it, because of the ease of administration. Effective replacement therapy may require as many as three tablets four times daily.

The new preparations, such as desoxycorticosterone, should probably be avoided at present until more of the details concerning these synthetic substances have been established.—E. S. Gordon, M. D., Madison.

FILM ON APPRAISING THE NEWBORN AVAILABLE

The recently released talking motion picture, "Appraisal of the Newborn Infant," may be obtained by county medical societies and medical groups from the Bureau of Maternal and Child Health, State Capitol, Madison. The film was prepared under the auspices of the Bureau by the departments of medicine, pediatrics and visual education of the University of Wisconsin. Dr. H. K. Tenney, Madison, prepared the script for the picture.

THE WISCONSIN MEDICAL JOURNAL

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« « « EDITORIALS » » »

99th ANNIVERSARY MEETING, STATE MEDICAL SOCIETY OF WISCONSIN
September 18, 19 and 20, 1940, Milwaukee

Misuse of Silver Preparations

IN THESE days of marked gold scarcity, we notice with dismay an over abundance of silver, not in the pockets, but in the bottles of the medical profession and patients. Medically and therapeutically the use of silver and silver preparations should be regulated.

The silver derivatives are as popular with the general public as aspirin, and, lately, as the barbiturates, epinephrine and sulfanilamide. The public learns of their efficacy without their dangers and side actions. This is in a large measure due to the unnecessary and sometimes harmful diffusion of information to the layman through the medium of the daily press, radio, and pseudo-scientific publications appealing to the general public. Sharing the guilt with the physician is the counter-prescribing and dispensing pharmacist who refills indefinitely a prescription designed to be used only over a short period of time.

The continued use of silver preparations leads to a cosmetic defect or blemish difficult to hide, argyrosis or argyria. We have seen a large number of cases of this disorder within the past six months, and think a word of warning is timely. These cases were all due to use of the silver derivatives, mainly argyrol, rather than to silver nitrate.

When silver nitrate in a strong solution (15 grains to the ounce) is applied to the conjunctiva a pellicle forms which is silver chloride deposited in the cell substance. A solution of this strength will cause a precipitation with tissue penetration sufficient to totally destroy the cells, and they will be cast off, disposing of most of the precipitated chlorides. The weaker silver solutions, argyrol in particular, cause deposition of silver chloride without cell desquamation, allowing the chlorides to remain in the tissues. This effect is cumulative, and argyrosis will be the end result of continuous usage. Consequently, the weaker silver preparations present more dangers than silver nitrate. Elastic tissue has an affinity for silver. One of the corneal layers, Descemet's membrane, is histologically modified elastic tissue,

which accounts for the predisposition of the cornea to silver stain and the presence of a dark circumcorneal ring.

E. von Skramlik reports a case in which argyrol was instilled into the tear sac daily for three weeks, and then occasionally for a period of seven months, following which a probe could not be introduced into the tear duct. Upon removal of the tear sac a coating of metallic silver was found in the tissues. De Schweinitz mentions a discoloration of the skin of nose and cheeks following conjunctival instillation of argyrol in the presence of a nasal fracture.

Argyrosis is a condition which, when present, causes embarrassment both to the patient and the physician. It is difficult to disguise or conceal the dirty gray or yellowish brown discoloration of cornea, conjunctiva, and surrounding structures. The individual tissue susceptibility to silver preparations varies widely, and a period of treatment that might cause no ill effects in one person will lead to permanent discoloration in another. Hence, caution should be the watch-word in the use and prescribing of the silver derivatives. A rigid supervision can be exercised over all patients under active office treatment. But, if a silver preparation is prescribed for home use, the patient should be warned its use will lead to argyrosis if continued indefinitely. The recipient of such a prescription should be warned also against recommending it to others for conditions superficially resembling his own.

A patient with a well defined argyrosis is a walking testimonial to the inefficiency and carelessness of the treatment of Dr. X, and may leave the luckless practitioner in danger of a suit for malpractice. Rather than risk such an eventuality, it is better to exercise caution and supervision in the use of the silver derivatives.

An Editorial in One Sentence

"Why should I have to *ask* our family doctor if the time has come for my children to have preventive inoculations?" asks the mother of four.

THE PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association advocates:

1. The establishment of an agency of federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

Total Disability

THE *New York State Journal of Medicine*, February 1, 1940, made the following editorial comment on total disability:

Physicians are often called upon to testify as to the degree of disability which a patient has sustained as the result of a disease or accident. Frequently, the doctor's testimony is of paramount importance in guiding the Court in its evaluation of the merits of a plaintiff's suit to validate his claim covered by a health, accident, or disability insurance contract. Some of these contracts read, in effect, that payment will be made to the policyholder if bodily injury or disease renders him *totally and permanently disabled* so as to prevent him from engaging in *any* occupation and performing *any* work for compensation.

In this connection, the decision of the St. Louis Court of Appeals in Missouri[1] brings us an im-

[1] J.A.M.A. 114: 187 (Jan. 13) 1940.

portant opinion, and we quote from the medicolegal abstracts of the *J.A.M.A.*: "To be permanently and totally disabled, continued the court, within the meaning of a policy of insurance such as the one sued on in this case, it is not necessary that the insured be inert and absolutely helpless; it is sufficient if it is shown that his infirmity renders him unable to perform, in the usual and customary manner, substantially all the material duties of his own occupation, business or profession or of any other occupation, business or profession which his *age, training, experience, education and physical condition would fit him for except for his disabling infirmity.*" [Italics ours.]

The significance of the Court's opinion lies in the last part; namely, that it considers the disabling character of the infirmity in relation to age, training, experience, and education of the individual. Therefore physicians, when called to testify in such cases, should give mature consideration to this phase of the problem so that they can materially contribute to the solution of what constitutes *total disability* in a given case.

Our Appreciation Due

JUST as the county medical society is the foundation of medical organization, the secretary of the county medical society is the keystone.

There are fifty-two county medical societies in Wisconsin, and of this number only one has a salaried secretary. Fifty-one secretaries are practicing physicians who give most liberally of their time and not infrequently of their funds to make their societies successful, in the interests of their fellow practitioners and the public.

One of the duties of county secretaries is the annual collection of dues. It will greatly lessen their work and the demands upon their time if each member will endeavor to place his dues in the hands of his local secretary early in March.

This will be an acknowledgment of the local secretary's effort that every physician can make and that will enable the state's membership record, sent to the American Medical Association on March 31, to attain a new high.

"I Wonder . . ."

DESPITE the fact it is often said "a prophet is not without honour, save in his own country and in his own house," our State has had many great authors whose writings deserve the recognition they received from the people of Wisconsin. One such is Ray Standard Baker who used the pen name, David Grayson, to write his "Adventures in Understanding."

In these days when the physician on the firing line sometimes feels a sense of inadequacy in combating with effectiveness the constant bombardment by those who are willing to make medicine the plaything of politics rather than the handmaiden of science and the servant of the people, it is particularly apropos that we recall what David Grayson had to say about just this situation; namely—

> I wonder if ever you change human beings with arguments alone: either by peppering them with little sharp facts or by blowing them up with great guns of truth. You scare 'em, but do you change 'em? I wonder if ever you make any real difference in human beings without understanding them and loving them. For when you argue with a man (how much more with a woman), you are somehow trying to pull him down and make him less (and yourself more); but when you try to understand him, when you like him, how eager is he then to know the truth you have; and you add to him in some strange way, you make him more than he was before; and at the same time, and that is the sheer magic of it, you yourself become more.

Who understands his people and their problems better than the family physician who lives with them because he loves them? *He* can give them the understanding they seek and need in this day of statistical attacks that too frequently conceal rather than reveal the real truth.

SPRING CLINIC DAYS

Wausau—April 24 Watertown—April 25 La Crosse—April 26

Keep one of these dates open. See pages 202-205 for complete details

. . . . THE PRESIDENT'S PAGES . . . .

Valley Forge

AMERICAN Medicine today represents the flower of our ancient profession in full bloom. The Sunday supplements are full of its achievements,—the public eager to read of its latest discoveries. When some half dozen men and women meet to form a new organization, one of their first thoughts is to do something for the sick.

Unfortunately, however, we find medicine standing upon the doorstep with its hat in hand, begging the pardon of its patrons, like a symphony player who has struck the wrong note. In the public's opinion the musical score is wonderful but the players sour. Perhaps we have been too smug, perhaps we have accomplished much and have stood by, expectant of the public's acclaim; or, perhaps, we have been too busy doing great things, and have failed to notice that people generally are getting all they can for themselves these days—a sort of "devil take the hindmost" attitude.

Be that what it may, Medicine realizes today that for the past twenty-five years the trend in political thinking and legislation affecting medicine, medical practice, and health has been against us. Most of us will agree that it has taken us a long time to realize it,—a long time to realize the insult. In spite of great pressure from high places, in spite of political expediency, in spite of propaganda, our patients, the public, have stood blinking in the great light, wondering whether the accusations were true, but not exactly caring to desert us in our hour of trouble.

In a way, we are to blame for our plight because we failed long ago to go out and inform the public as to our position in the controversy. I saw Dean Carey struggle with it a year ago; he did his best to arouse the doctors of this State to sally forth to the school house and talk in their own defense. He never received the support to which he was entitled.

The answer to our prayer seems to be here in the National Physicians Committee for the Extension of Medical Service. When its literature reaches your desk, do not throw it aside. Read it and contribute to it if you believe in the individuality of medical practice. Whether you contribute to it or not, write to the National Physicians Committee for the Extension of Medical Service, 700 N. Michigan Ave., Chicago, Illinois, and have your name put on the mailing list.

It is hoped that five million copies of the "Priceless Heritage" and "The Achilles Heel of American Medicine" will be placed in the hands of influential citizens and our legislators. They are yours for the asking, get them and pass them out.

We have muddled around long enough. The spokesman for whom we have asked so long is here in the name of this new organization. It will fail if you fail to support it; it will be a tremendous agent for the good of your patients and yourself if you give your support.

Writing these lines a few days after Washington's birthday for the March Journal, these thoughts run through my mind—the American independence was won at Valley Forge and not at Saratoga. George Washington won it when he refused to let bitter discouragement become utter despair. Every human being at some time or other, and I include the profession of medicine here, comes to his Valley Forge. Enduring discouragement but sticking it out, he wins there the decisive victory of his life. Each one of us, by his conduct at Valley Forge, decides whether he is to be a success or a failure in the world.

R. G. Arrum

Program For Spring Clinic Days Announced by Council on Scientific Work

THE Council on Scientific Work of the Society, at its meeting held in Madison on January 10, reviewed the projected program for the spring clinic days which had been arranged by Dr. James A. Evans, La Crosse, a member of the Council on Scientific Work.

Outstanding men in the fields of surgery, internal medicine, cardiology, pediatrics, dermatology, radiology, obstetrics and clinical pathology have been retained by the Council on Scientific Work to bring every physician in Wisconsin a concentrated one-day program packed with recent discoveries on new modes in treatment that may be applied by the physician in his everyday practice.

This is the second annual clinic day session presented under the auspices of the Council on Scientific Work. The clinic days will be presented this year in Wausau on Wednesday, April 24, in Watertown on Thursday, April 25, and in La Crosse on Friday, April 26. The program is scheduled to begin at 10:00 a.m., with the morning session devoted essentially to a clinic program being presented in the fields of surgery, medicine, pediatrics and dermatology. The afternoon sessions will be devoted to discussions by members of the faculty who are presenting the courses. At 6:00 p.m. those attending the clinic days will elect to attend one of four dinner round-table discussions or question boxes in the fields of obstetrics, medicine and roentgenology, surgery, or pediatrics. At these evening round-table dinners an opportunity will be given those attending to query the leaders of the round-table dinners on questions pertaining to the different fields covered by the individual men. Questions will be submitted to the speakers on written slips which will be provided for each person attending the meeting. The evening sessions will be devoted to a discussion on peripheral vascular disease, and clinical-roentgenological conferences in cardiology.

An innovation in the program for this year is the inclusion of a conference period in which individual physicians may discuss with John W. Harris, M.D., questions pertaining to obstetrics and gynecology which may be perplexing them. A separate room will be made available each afternoon where members attending the conference may have an opportunity to discuss personally with Dr. Harris obstetrical and gynecological problems.

The registration fee for this one-day graduate course is but $5. This fee, it is anticipated, will be barely sufficient to cover the cost of transporting the faculty from one city to another and to pay the traveling expenses of these outstanding men to Wisconsin and return to their homes, plus a nominal honorarium. This registration fee also includes the cost of the evening dinner round-table, but it does not, as it did in 1939, cover the cost of the noon luncheon. A registration blank and a descriptive folder will be issued to all members of the State Medical Society late this month. It is urged that as soon as the registration blank reaches you, you fill it in and forward it to the State Medical Society office, Madison, Wisconsin, so that a proper reservation may be made for you at the clinic center selected by you. The registration fee for the one-day session is $5.

Special committees have been appointed by all county medical societies where the clinics are to be held. The committees selected are:

Jefferson County:

H. P. Bowen, M.D., Watertown, Chairman
T. Abelmann, M.D., Watertown
W. S. Waite, M.D., Watertown

Marathon County:

H. W. Christensen, M.D., Wausau
E. P. Ludwig, M.D., Wausau

La Crosse County:

M. A. McGarty, M.D., La Crosse, Chairman
G. F. Malin, M.D., La Crosse
J. C. Harman, M.D., La Crosse
H. A. Jegi, M.D., Galesville (Councilor)

These committees will be in charge of local arrangements for physical facilities, such as meeting rooms, and also of arrangements for clinical material for the morning clinics.

A brief description of the physicians who are participating in the presentation of this excellent graduate program, which is being brought to the door of every physician in Wisconsin, is set forth here, together with a complete program as it will be presented in Wausau on Wednesday, April 24, in Watertown on Thursday, April 25, and in La Crosse on Friday, April 26.

PROGRAM

WAUSAU—APRIL 24
WATERTOWN—APRIL 25
LA CROSSE—APRIL 26

WILLIAM S. MIDDLETON, M.D.
General Chairman and Correlator

10:00 A. M.—Announcements

10:00–10:45 Surgical Clinic
Geza de Takats, M.D., Chicago
Associate Professor Surgery, Univ. of Illinois College of Medicine; Attending Surgeon, St. Luke's Hospital
Treatment of Varicose Veins

10:45–11:35 Medical Clinic
Samuel A. Levine, M.D., Boston
Assistant Professor Medicine, Harvard University Medical School; Senior Associate Medicine, Peter Bent Brigham Hospital
Merrill C. Sosman, M.D., Boston
Assistant Professor Roentgenology, Harvard University Medical School; Roentgenologist, Peter Bent Brigham Hospital
Valvular Diseases of the Heart

11:35–11:50 Recess

11:50–12:30 Pediatric Clinic
A. Graeme Mitchell, M.D., Cincinnati
Professor Pediatrics, Cincinnati College of Medicine
Case of Malnutrition

12:30– 1:00 Dermatological Clinic
Paul A. O'Leary, M.D., Rochester
Professor Dermatology and Syphilology, University of Minnesota Medical School
Skin Problem Cases

MERRILL C. SOSMAN, M.D.

Assistant Professor of Medicine, Harvard Medical School; Roentgenologist, Peter Bent Brigham Hospital. Degree of Doctor of Medicine, Johns Hopkins University School of Medicine. Member Suffolk District Medical Society, the Massachusetts Medical Society, the American Medical Association, the North American Radiological Society, the Roentgen Ray Society, and the New England Roentgen Ray Society.

SAMUEL A. LEVINE, M.D.

Senior Associate in Medicine, Peter Bent Brigham Hospital; Assistant Professor of Medicine, Harvard Medical School. Author "Coronary Thrombosis: Its Various Clinical Features" and "Clinical Heart Disease." Member of the Suffolk District Medical Society, the Massachusetts Medical Society, the American Medical Association, the American Society for Clinical Investigation, the Association of American Physicians, the American College of Physicians and the New England Heart Association.

1:00–2:00 Lunch

2:00– 2:30 W. D. Stovall, M.D., Madison
Professor Hygiene, University of Wisconsin Medical School; Director Wisconsin State Laboratory of Hygiene
(1) Practical Clinical Application of Renal Functional Tests
(2) Clinical Interpretation of Certain Serological Tests in Diagnosis of Communicable Diseases Including Syphilis.

2:30– 3:15 Paul A. O'Leary, M.D.
(1) Oral Bismuth and Its Place in the Treatment of Syphilis
(2) Eczema

3:15–3:25 Recess

3:25– 4:00 Merrill C. Sosman, M.D.
Pitfalls in Gastrointestinal Fluoroscopy
Remarks on Proper Technic in Such Examinations

4:00– 4:45 A. Graeme Mitchell, M.D.
Common Endocrine Disturbances in Children

4:45–4:55 Recess

4:55– 5:40 John W. Harris, M.D., Madison
Professor Obstetrics and Gynecology, Univ. of Wisconsin Medical School.
Management of Some Common Complications of Pregnancy

5:40–6:00 Recess

6:00–8:00 Round-Table Dinners

(All questions to be handed in written on a slip of paper at the beginning of the dinner)

OBSTETRICS
Obstetrical Question Box—John W. Harris, M.D.

MEDICINE AND ROENTGENOLOGY
Medical and Roentgenological Question Box — Drs. Levine, Sosman, O'Leary, Stovall and Middleton

SURGERY
Question Box on Pre- and Post-operative Care—Geza de Takats, M.D.

PEDIATRICS
Pediatric Question Box—A. Graeme Mitchell, M.D.

8:00–8:15 Recess

8:15– 9:15 Geza de Takats, M.D.
Peripheral Vascular Disease

9:15–10:15 Samuel A. Levine, M.D.
Merrill C. Sosman, M.D.
Clinical and Roentgenological Conference in Cardiology

N.B.—John W. Harris, M.D., will be available two hours of each afternoon, the room and hours to be designated at each city, for personal consultation on questions in obstetrics and gynecology.

JAMES A. EVANS, M.D.

Member of the Council on Scientific Work of the State Medical Society of Wisconsin who arranged the spring clinic days program.

JOHN W. HARRIS, M.D.

Professor of Obstetrics and Gynecology, University of Wisconsin Medical School; obstetrician and gynecologist, Wisconsin General Hospital. Degree of Doctor of Medicine, Johns Hopkins University. Formerly Associate Professor of Obstetrics, Johns Hopkins University. Member of Dane County Medical Society; the State Medical Society of Wisconsin; the American Medical Association; Diplomate, American Board of Obstetrics and Gynecology; the Central Association of Obstetricians and Gynecologists and the American Gynecological Society.

PAUL A. O'LEARY, M.D.

Professor Dermatology and Syphilology, Graduate School of University of Minnesota (The Mayo Foundation); head of the Section of Dermatology and Syphilology of the Mayo Clinic. Degree of Doctor of Medicine, Long Island College of Medicine. Member Olmsted–Houston–Fillmore–Dodge County Medical Society, the Minnesota State Medical Association, the American Medical Association, American Board of Dermatology and Syphilology and the National Health Council and Secretary General of the Tenth International Congress of Dermatology and Syphilology.

W. D. STOVALL, M.D.

Director State Laboratory of Hygiene, University of Wisconsin; Acting Superintendent Wisconsin General Hospital. Degree of Doctor of Medicine, Tulane University. Former member of the Wisconsin State Board of Health. Member of the Dane County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the American Society of Clinical Pathologists, the American Public Health Association and the Society of American Bacteriologists.

GEZA de TAKATS, M.D.

Associate Professor of Surgery, University of Illinois School of Medicine; Attending Surgeon, St. Luke's Hospital, Chicago. Master's Degree in Surgery, University of Budapest Medical School. Formerly Associate Professor of Surgery, University of Budapest Medical School; traveling fellowship, Rockefeller Foundation. Member of Cook County Medical Society, Illinois State Medical Society, American Medical Association, American College of Surgeons and Central Society for Clinical Research.

A. GRAEME MITCHELL, M.D.

Professor of Pediatrics, University of Cincinnati College of Medicine. Degree of Doctor of Medicine, University of Pennsylvania Medical School. Formerly Associate in Pediatrics, University of Pennsylvania. Co.-author, "The Diseases of Infants and Children," Mitchell and Griffith, member editorial board American Journal of Diseases of Children. Member of the Academy of Medicine of Cincinnati, the Ohio State Medical Association, the American Medical Association, the American Association for the Advancement of Science, the American Pediatric Society, the American Academy of Pediatrics, and other special societies.

Minutes of the Council; Milwaukee, January 6, 1940

1. Call to Order

The Council was called to order at 9:00 a. m., Saturday, January 6, 1940, in the library of the University Club of Milwaukee.

2. Roll Call

The following were present, constituting a quorum: Councilors Gavin, Butler, Johnson, Gramling, Jegi, Krahn, Christofferson, Fitzgerald, Blumenthal, Lambert, Clark, Heidner and Pechous; President Arveson, Past President Rector, President-Elect Sproule, Vice Speaker Kurten, Treasurer Sisk, Secretary Crownhart, Assistant Secretary Larson and Delegates to the American Medical Association, Smith and Sargent. Others who attended during a part of the session were Dr. William M. Jermain, president of the Medical Society of Milwaukee County, Dr. Stanley J. Seeger, Milwaukee, chairman of the Committee on Industrial Health, and Dr. W. P. Blount, Milwaukee, temporary secretary, Orthopedic Section.

3. Approval of Minutes of November Meeting

Upon motion by Fitzgerald–Christofferson, the minutes of the November meeting of the Council, as published in the December issue of the Wisconsin Medical Journal, were approved.

4. Election of a Chairman of the Council for 1940

Upon motion by Councilor Christofferson, variously seconded, Dr. S. E. Gavin was nominated to succeed himself as chairman of the Council for the year 1940. There being no further nominations, the secretary was instructed to cast a unanimous ballot for Dr. Gavin and the ballot was so cast.

5. Election of a Treasurer of the Society and of the Council for 1940

Upon motion by Clark–Jegi, Dr. Ira Sisk was nominated to succeed himself as treasurer of the Society and treasurer of the Council for the year 1940. There being no further nominations, Secretary Crownhart was instructed to cast a unanimous ballot for Dr. Sisk and the ballot was so cast.

6. Election of a Secretary of the Society and of the Council for 1940

Upon motion by Rector–Christofferson, Mr. J. G. Crownhart was nominated as secretary of the Society and of the Council for the year 1940. There being no other nominations, the chairman cast a unanimous ballot for Mr. Crownhart.

7. Report of the Treasurer

Dr. Ira Sisk, treasurer, presented his report for the calendar year 1939 as follows:

STATE MEDICAL SOCIETY OF WISCONSIN

REPORT OF THE TREASURER—DR. IRA SISK

For the Year Ended December 31, 1939

	General Fund	Medical Defense Fund	Combined Funds
Cash on hand, January 1, 1939	$(1,673.49)	$3,864.39	$ 2,190.90
Receipts			
Membership dues	36,476.62		36,476.62
Special assessment dues	19,437.70		19,437.70
Annual meeting revenues	4,389.50		4,389.50
Interest on investments	397.50	337.45	734.95
Proceeds from sale of securities	3,195.53	2,185.47	5,381.00
Graduate course fees	2,140.00		2,140.00
Sale of recording machine	110.00		110.00
Sale of books	326.88		326.88
Share of rent, Wisconsin Medical Journal	45.00		45.00
Share of Social Security taxes, Wisconsin Medical Journal	89.16		89.16
Miscellaneous receipts	453.20		453.20
Total receipts	$67,061.09	$2,522.92	$69,584.01
Total to be accounted for	$65,387.60	$6,387.31	$71,774.91
Disbursements			
Salaries	$19,718.97	$	$19,718.97
Office expense	8,372.29		8,372.29
Health and public instruction	992.98		992.98
Secretaries' conference	483.09		483.09
Wisconsin Medical Journal	1,200.00		1,200.00
Annual meeting	5,946.39		5,946.39
1938 Annual meeting unpaid bills	180.21		180.21
Hygeia	257.50		257.50
Delegates to A.M.A.	198.20		198.20
Legal services	1,938.21		1,938.21
President's account	500.00		500.00
Council and committees	2,096.75		2,096.75
Insurance on secretary	244.50		244.50
Travel expense of secretary	1,259.92		1,259.92
Auxiliary	138.85		138.85
Social Security taxes for 1939	783.32		783.32
Social Security taxes for prior years	2,743.69		2,743.69
Income tax determination	657.40		657.40
Public education	476.69		476.69
Committee on Public Policy	6,234.01		6,234.01
Voluntary sickness insurance trials	4,337.75		4,337.75
Graduate courses	3,261.15		3,261.15
Investment securities purchased		2,111.94	2,111.94
Medical defense disbursements		1,666.20	1,666.20
Dues and assessments refunded	69.00		69.00
Exhibit space and round-table refunds	39.50		39.50
Total disbursements	$62,130.37	$3,778.14	$65,908.51
Cash on hand, December 31, 1939	$ 3,257.23	$2,609.17	$ 5,866.40

Securities Owned, December 31, 1939

General Fund	Rate	Maturity	Face Value
Dominion of Canada	2½%	8/15/45	$ 2,000.00
Dominion of Canada	3¼%	1/15/61	2,000.00
Pacific Telephone and Telegraph Company	3¼%	12/ 1/66	1,000.00
Milwaukee Gas and Light Company	4½%	3/ 1/67	2,000.00
Canadian National Railway Company	5 %	10/ 1/69	2,000.00
Total general fund securities			$ 9,000.00
Medical Defense Fund			
Milwaukee County Metropolitan Sewerage Bond of 1925	4½%	3/18/44	$ 1,000.00
United States Treasury Bonds	3¼%	4/15/44–46	2,000.00
Pennsylvania Power and Light Company	3½%	8/ 1/69	2,000.00
Southern California Edison Company, Ltd.	3¾%	5/ 1/60	2,000.00
Wisconsin Gas and Electric Company	3½%	4/ 1/66	1,000.00
Pacific Telephone and Telegraph Company	3¼%	12/ 1/66	1,000.00
Total medical defense fund securities			$ 9,000.00
Total securities owned			$18,000.00

Summary of Cash on Hand, December 31, 1939

	General Fund	Medical Defense Fund	Combined Funds
Treasurer's cash (First National Bank)	$3,257.23	$2,609.17	$5,866.40
Secretary's petty cash (American Exchange Bank)	300.00		300.00
Secretary's residuary balance (American Exchange Bank)	100.00		100.00
Secretary's 1940 advance dues (American Exchange Bank)	1,200.00		1,200.00
Totals on hand	$4,857.23	$2,609.17	$7,466.40

Discussion followed by Councilors Gramling, Fitzgerald, Butler, and Secretary Crownhart. The report was received by the chairman.

8. Report of the Secretary

Secretary Crownhart supplemented his interim report as presented to the Council in mimeographed form prior to the meeting. The report follows:

INTERIM REPORT OF THE SECRETARY

To the Council:

Membership

As of December 27 the membership for the year 1939 was 2,426 as compared with 2,391 a year ago, —representing a gain of 35. As of the same date, those in arrears for 1939 dues and who still resided in Wisconsin numbered but 40. This is the largest membership and the lowest number of members delinquent in dues in the history of the Society.

Finances

The Society opened the calendar year of 1939 with a general fund operating account deficit of $1,673.49. We will end the calendar year of 1939 with all current bills paid, a prepayment for 1940 and 1941 of over $500 on Social Security obligations, and with the deficit wiped out. This means a total gain in position during the year of $2,200.

The treasurer's report to be submitted separately will show that the general fund assets of the Society are bonds of a face value of $9,000 and uninvested cash from sale of bonds since September of slightly over $3,000 representing a total general fund surplus account of $12,000. It will be recalled that during the crisis period the Council used $12,000 from the surplus account. The present surplus represents but 28 per cent of the 1940 budget and seemingly efforts should be made to rebuild the surplus account until it represents a total equivalent to the annual budget.

The treasurer's report will also show a medical defense fund bond account of $9,000 with something over $2,500 in the current checking account. Against this there still remain accounts pending of undetermined amounts for defense of actions brought within the time limit prior to a closing of the fund, but which actions have not been completed in the courts to date. It is essential to maintain the complete integrity of this fund until all such actions shall have reached a final determination.

A report of two important budgetary items, the Journal and the annual meeting, are provided following, as well as a discussion of the Society's Social Security and tax position.

The Journal

A year ago the Council voted to reinstate the Blue Book but by devoting the December issue of the Journal to this informative material rather than publishing it as a separate book. The first Journal Blue Book was published in December. The additional publication cost, for which the Council made no appropriation in 1939, was $600. This item has been entered in the 1940 budget for it is apparent that this annual number of the Journal has met with a most enthusiastic response from the general membership. The section on poor relief laws and rulings was revised to date at a legal cost of $75, while other legal counsel assisted in preparing the material on income tax laws and like subject matter. Several members have written or orally advised your secretary that information gained from this one volume has made possible savings in cash representing considerably more than their dues.

Aside from this one non-recurring item of Journal expense met from Journal funds, mentioned above, the Journal is self-sustaining on the basis of 75 cents per member per year from the general fund. This is the lowest per member cost of any state journal of comparable size and circulation. The per member sums granted the Journal in other states as compared with the 75 cents in Wisconsin are: Minnesota $2, Colorado $2.50, Indiana $2, Connecticut $2.25, West Virginia $3, Texas $3, Iowa $1.89, Northwest Medicine $2, Michigan $1.50, Ohio $2, Nebraska $1.50, Tennessee $2, South Carolina $3, Missouri $1 and Pennsylvania $3.

The Journal financial statement accurately reflects its actual cost for included therein will be found its actual proportionate share of the office rent, light and service; its own postage, mailing costs, and stationery; its advertising solicitation costs; the salary of Miss Dorothy Cridland who devotes her entire time as editor of manuscripts and in Journal supervision; its own accounting costs; its share of old age and unemployment social security taxes; as well as the actual costs of cuts and printing.

Substantially the sole source of independent Journal revenue is from advertising. Holding to J.A.M.A. standards limits the field of advertising prospects. Furthermore, all state journals solicit their advertising of a national character through

the A.M.A.'s Cooperative Medical Advertising Bureau which means that a single journal may not raise its rates over others in a like circulation class without a loss rather than a gain in net revenues. The result is that the Wisconsin page rate of $22.50 is lower than the page rate of the Milwaukee Medical Times which has 40 per cent of the circulation and less than 34 per cent of the total content of the state Journal.

As of December 15 the Journal auditor drew off the following estimated financial data for the calendar year of 1939:

WISCONSIN MEDICAL JOURNAL

Madison, Wisconsin

INCOME AND PROFIT AND LOSS STATEMENT

Year ended December 31, 1939

Income		
Advertising		$9,127.64*
Subscriptions		81.20
Total		$9,208.84
Expenses		
Printing	$7,664.87	
Salaries	1,800.00	
Cuts	367.30	
Mailing	488.24	
Rent	210.00	
Accounting Service	180.00	
Miscellaneous Expense	63.41	
Editorial Expense	72.85	
Supplies	28.40	
Social Security Taxes	18.06	
Depreciation	12.42	
Discounts allowed	8.00	
Total		10,913.55
Publication (Loss)		($1,704.71)
Less: State Medical Society Appropriation		1,200.00
Net (Loss) for the year		$ 504.71)

* December C.M.A.B. advertising estimated at $425.00.

Balance Sheet—December 31, 1939

Assets	
American Exchange Bank	$1,236.72
Accounts Receivable	923.35
Office Equipment (net of depreciation)	101.85
Mailing Envelopes Inventory	162.85
Postage Deposit	4.59
Total Assets	$2,429.36
Liabilities and Surplus	
Copyright Deposit Overdrawn	$ 8.00
Surplus	2,421.36
Total Liabilities and Surplus	$2,429.36

Annual Meeting

A breakdown of the 1939 annual meeting expense is submitted herewith for the information of the Council and officers and as background for a consideration of the probable 1940 budget item. It is to be noted that in the years since the Society has grown to a size wherein it no longer has been possible to hold the meetings in various sections of the State, the officers have held that it was important that no costs of the meeting devolve year after year upon the one or two host county societies. This has been carefully avoided and to the mind of your secretary should be avoided as carefully for the future.

The 1939 income and cost statement follows:

ANNUAL MEETING, 1939

INCOME AND EXPENDITURES

Income		
1. Commercial exhibit space	$3,052.50	
2. Sale of tickets for annual dinner and round tables	1,259.00	
Expenditures		
1. Auditorium rentals, public address system, and guards:		
a. Commercial exhibit booths and expenses	738.82	
b. Scientific exhibit booths and expenses	325.00	
c. Public address system and Auditorium guards	125.75	
Total		$1,189.57
2. Travel of out-of-state speakers (15 speakers submitted accounts)	402.04	
3. Hotel expenses of out-of-state speakers	100.97	
4. Publicity to members and annual meeting programs	443.82	
5. Expenditures of program chairman (travel, long distance, and postage)	167.75	
6. Union operators for lantern slides and motion picture machines	196.60	
7. Rental of lantern slide projectors, motion picture machines, and screens	141.87	
8. Scientific exhibits, miscellaneous expense of chairman (in addition to Auditorium rental)	63.20	
9. Stenotype operator, House of Delegates and scientific sessions	259.05	
10. Cost of printing and mailing for solicitation of commercial exhibits	28.50	
11. Public liability and theft insurance on exhibits	83.75	
12. Annual dinner and round tables (all to hotel except for $60 for guards)	1,244.61	
13. Badges for members, guests, and exhibitors	150.11	
14. Staff expenditures, cost of having nine staff members in Milwaukee for from four to eight days, railroad and hotel	316.69	
15. Smoker (entertainment $75; food $157)	232.00	
16. Golf tournament	67.36	
17. Woman's Auxiliary (entertainment for night of men's smoker $250; printing of programs, tickets, badges, and publicity $218.21)	468.21	
18. Miscellaneous, telephone service through Physicians' Exchange Bureau	42.81	
19. Telephone and telegraph	45.55	
20. Public stenographer for committees of the House	9.95	
21. Commercial exhibits,—supervising of erection, dismantling, and assisting exhibitors	150.00	
22. Assistant to secure and place viewboxes and miscellaneous equipment as needed throughout week	50.00	
23. Council Award	24.25	
24. Gavel for retiring president	10.00	
25. Auditorium guide and telephone pages	14.25	
26. Miscellaneous	9.40	
Total expenditures		$5,912.31
Total income		4,411.50
Expense of meeting		$1,600.81

Note: After subtracting the cost of commercial exhibit space at the Auditorium, the exhibit manager, and exhibit solicitation, the profit from the sale of commercial exhibit space was $2,135.18.

It will also be noted that because we had the good fortune to go over somewhat our annual dinner guarantee at the hotel and because the round tables were completely filled, we made a profit from these two events of $14.39 instead of incurring a loss that in former years always ran in the neighborhood of $150.

Social Security and Income Tax Status

It will be recalled that the Society has been held subject to both the unemployment and old age assistance. Under the act the State Society must pay the full amount of 3 per cent of the total pay roll until a reserve fund has been established after which the cost to the Society will drop to three-tenths of 1 per cent. Under the old age assistance act, the State Society must pay 1 per cent of its pay roll (up to $3,000 for any individual salary), while the employee has a like percentage deducted from the monthly pay check. Thus the annual budget of the Society must include for the present a sum equal to 4 per cent of the pay roll for these two tax features.

Early in the fall of 1938, however, the Federal Income Tax Department held that the Society was operating neither as a business league nor as one devoted to the promotion of scientific attainments, and accordingly proposed to assess a corporate income tax going back over a long period of years. This ruling based on the old and now discontinued medical defense fund was plainly in the face of all the facts and overwhelming evidence to the contrary, but the most strenuous efforts of legal counsel were required before the Income Tax Division reversed its position to hold that the Society was exempt as a business league. The effect of such a tax would have been literally to bankrupt the Society.

The action of your State Society was in some measure controlled by the situation that confronted the A.M.A. You will recall that the A.M.A. was in the early days of the Social Security Act held exempt on the ground that it was a scientific organization. At some later date, without any warning to the A.M.A., that ruling was reversed and the implications of the reversal could well have brought in application of the Internal Revenue Law at some later date. At the same time, we were confronted with the situation that had developed with respect to some other state societies and one or two county societies. For all these various reasons it was felt that we had won a distinct victory in securing reversal of the ruling with respect to the income tax, and thus the Society rather willingly complied with the unemployment law of the State and with the applicable provisions of the Social Security Act.

Amendments to Constitution and By-Laws

Several years ago the American Medical Association created a committee to report a model constitution and by-laws for state societies. (See page 1109 ff. of the Blue Book issue of the Journal). When such model was reported, it was adopted by Wisconsin with some minor amendments at the time and since that date. It now appears that the purpose clause as so prepared contains statements contrary to fact and for purposes of accuracy, should be amended. It is therefore proposed by the secretary that the Council take under consideration such amendment and the following amendments to the By-Laws suggested by legal counsel to make certain that the By-Laws conform to practice and precedent.

1. **Amend Article II of the Constitution**, "Purpose," striking out the words "to guard and foster the material interests of its members and protect them from imposition."

2. **Amend Chapter XI of the By-Laws, Sec. 3.** referring to eligibility of physicians for membership in a county medical society so as to add the italicized words and repeal the word "to" in the sentence that follows: "Every reputable and legally qualified physician who is a citizen of the United States and who is a bona fide resident of the same county shall be eligible *to apply for* (to) membership so long as ___ etc. ___."

3. **Add a final sentence to Section 3** to read: "A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed."

Waukesha and Dodge Counties

Pursuant to direction of the Council, your secretary has addressed the Waukesha and Dodge County Medical Societies with reference to the subject matter of the Council determination of the legality of the election of their councilor. Both meetings were very well attended.

"Socialized Medicine"

As the Council is aware, during the last two years your secretary has made a large number of addresses on the work and position of medicine before lay organizations. It has been the conviction of your secretary that this effort, time consuming though it was, was worth doing. The requests for similar addresses continue to be received in some number and so far as is possible will be accepted unless the Council feels that a change in policy is indicated. All out-of-state addresses, except for unusual situations such as filling two engagements for Dr. Sleyster during his illness, are rejected.

The Medically Indigent

The secretary of the Wisconsin Conference of Social Work has just made inquiry of your secretary whether he would represent the Society in a study of laws, with the thought of new legislation, affecting the authorization of sickness care for the medically indigent. The offer was accepted subject to determination by the Conference in February as to whether such study shall be made a part of the Conference effort for the year. Should such study be entered upon it will be costly of our time and effort but Medical Society representation and participation seem to be most desirable.

Examination of Employees in Industry

The Council has been forwarded, from the state office, informative material concerning the plan of the Industrial Commission for pre-employment and periodic health examinations in industry. This program well may develop into a project involving $3,000,000 to $4,000,000 annually. Your secretary has been giving continuously of his efforts to assist the State Society's newly created Committee on Industrial Health headed by Dr. S. J. Seeger (also chairman of the Council on Industrial Health of the American Medical Association).

Dr. Seeger will report on the committee effort at the January Council meeting and to the mind of your secretary the subject deserves the most earnest consideration of the Council. This plan well may be one wherein a few physicians on a full-time basis attempt to do such work on a mass basis, or it may be one in which the entire force of the family physicians of the State may be mobilized to accomplish the greatest possible health gains. In the moulding of this program during the year to follow, the Council may indeed wish to consider the possible advisability of making a special grant to the committee for a temporary full-time assistant. Once the pattern of procedure is established it is often difficult to change. The present apparent op-

portunity seems worthy of special consideration by the Council. The subject is mentioned here that its importance to the membership as well as to the public purpose to be served, may be emphasized.

Farm Security Administration

The Council will recall that the F.S.A. has approximately 8,000 standard loan client families in the various counties throughout Wisconsin. This federal agency is now compiling the results of a questionnaire on the medical needs and outstanding sickness bills of all of these clients together with the results of a questionnaire to physicians throughout the State.

On the basis of preliminary returns it appears that something less than 50 per cent of the client questionnaires are being returned. Of this number approximately 50 per cent (25 per cent of the whole) indicate that it is the clients' belief that they require some medical service. These figures are based upon a very incomplete tabulation and the percentages may be increased materially.

Your secretary had Mr. Larson make one-day inquiries in two counties where preliminary returns had been received and tabulated. It is too early to give any considered opinion, but advice of the Council is sought as to what procedure should be followed to make certain that any person who so indicates a desire for sickness care receives it.

Voluntary Sickness Insurance Trials

At the December meeting of the Council's Executive Committee, request was made of the secretary that the report on this subject which the Council did not reach in its last meeting, be given early in the January meeting. The assistant secretary has prepared the statement that follows, that each Councilor may have this portion of the report to read at his leisure prior to the meeting. In the meeting itself, this report will be supplemented by a brief confidential aggenda. Mr. Larson's report follows:

DOUGLAS COUNTY

I. Solicitation

1. On January 25, 1940, there will have been completed a full year of intensive solicitation by the officers of the Cooperative Health Association. The offices of the Association were opened on January 16, 1939, and a manager selected by the Association to work with the directors to enroll members.

2. The plan started operation on July 1, 1939 with 138 service-eligible subscribers. The Association now (December 26, 1939) has 163 active units that are eligible to secure medical benefits under the plan.

3. Solicitation of subscribers has continued throughout the period of the trial. The solicitation efforts of the officers of the Cooperative Health Association since the publication of the preliminary report of the Advisory Committee on Voluntary Sickness Insurance have been (a) a continuation of the personal solicitation efforts of the officers of the Cooperative Health Association and the manager; (b) scheduling of meetings where the Cooperative Health Association was discussed. Particularly noteworthy were the meetings sponsored jointly by the Cooperative Health Association and the Farm Security Administration. A series of meetings was scheduled throughout Douglas County to which were invited the 150 clients of the Farm Security Administration and any other interested citizens. Notices of these meetings were sent to each client by mail, notices appeared in the newspapers, and spot radio announcements were made over station WEBC. A total of ten families turned out for the meetings. A meeting was scheduled for Brule to which no families came. Another meeting was scheduled at Poplar with no attendance. A third meeting was posted for Solon Springs. To this meeting came one client family of the Farm Security Administration and one other family in the community that had heard of the meetings. A meeting was held at Dairyland which was attended by five client families and a meeting held near Manitou Falls was attended by four client families. (c) The third effort by the Association to enlist members in the plan was a membership campaign conceived and executed by the officers of the Association. The campaign consisted of offering to each of the 163 units then enrolled in the plan a free month's dues to the Association for each ten additional units they induced to belong and enroll in the plan. As of December 26, 1939, this effort resulted in no increase in membership.

II. Services

1. The services which have been rendered to individual subscribers under the plan have been essentially for small services such as one or two office calls during the course of the month. There has been only one bill of a major character paid by the Association, that being for a chronic ailment (of a mastoid), and the patient being referred to an institution outside the territorial limits established under the plan.

There have been, of course, instances in which tonsillectomies, minor surgical procedures, and some refractions have been performed. During the first five months of operation of the plan no country calls were made. (The plan pays for the physician's services plus 10 cents per mile for country calls. The patient pays the remaining 40 cents per mile direct to the physician).

Contrary to some thought there was no immediate deluge of demands for services under the plan. The first month's operation was the lowest service demand month witnessed to date in the trial. The demands since the first month have fluctuated markedly, but have never gone below the first month's demands. During the later part of December it is reported that there have been demands on the plan for major services. It is understood that an appendectomy and tonsillectomy were performed, and a patient who might possibly have a carcinoma of the stomach has been placed in a hosptal for observation. If these reports are true, they together with the normal day in and day out demands for ordinary office calls will materially change the experience for the first five months.

2. It is to be noted that there are approximately 425 persons covered by this plan. It seemed most unusual that during the first five months' experience there had been no acute conditions developing among this many people. (The average number of individuals per physician in Wisconsin is 970). The months to come should present more of an accurate picture of the health experiences of a group such as this one.

III. Finances

1. Twenty per cent (20%) of the dues received from subscribers is set aside for administrative purposes. This amounts to approximately $70 to $75 per month. The overhead of the Association varies from $140 to $175 per month. The administrative loss each quarter has been about $250. This loss has been borne by the State Medical Society of Wisconsin from its grants-in-aid fund.

2. During the first five months the Association would have been in a position to pay out 97+ per cent on a normal schedule of fees but this figure is based upon the fact that the State Medical Society contributed to the administrative (overhead) losses.

If this loss had not been met by the State Medical Society the participating physicians would have received 76.9+ per cent of their normal schedule of fees. The experience during the sixth and succeeding months may materially alter these percentages.

FINANCIAL SUMMARY

Six Months' Experience Cooperative Health Association

	Amount of Approved Statements	Medical Trust Funds	Administrative Costs	Administrative Income (20%) Dues)	Administrative Loss	State Med. Society Contribution
July	154.50	294.44	182.03	58.48	123.55	125.00
Aug.	309.25	248.20	155.51	66.51	89.00	125.00
Sept.	417.00	264.00	170.67	66.00	104.67	
				7.50*	(7.50)	
Quarterly Total	880.75	806.64	508.21	198.49	309.72	250.00
Oct.	302.00	272.60	151.70	71.65	80.05	100.00
Nov.	183.00	292.48	140.92	75.12	65.80	100.00
Dec.	554.00	290.00e 5.66**	175.00e	75.00e	100.00e	50.00
Six Months Total	1919.75	1667.38	975.83	420.26	555.57	†500.00

Administrative Income Dues	420.26
Organization Balance	24.39
Purchase One Share Stock	50.00
Total Administrative Income	494.65
State Medical Society	500.00
	994.65
Six Months' Administrative Cost	975.83
	18.82
Administrative Balance 1940	18.82

* Application fees in the amount of $7.50 were received by the Association during the first quarter and credited to the administrative account.

** The separate item of $5.66 in the medical trust fund account represents the difference between 86.7 per cent which was the amount payable for the first quarter medical services, and the 86 per cent which was actually paid to participating physicians.

† The State Medical Society has previously contributed $250.00 to the organization expenses of the Association.

e—Estimated. Actual data not available at time summary was prepared.

MILWAUKEE COUNTY

I. Solicitation

1. The solicitation efforts by the voluntary citizens committee at Greendale continued after the publication of the preliminary report of the Advisory Committee on Voluntary Sickness Insurance wherein the solicitation efforts up to the time of publication were set forth. The committee at Greendale divided the community into sections each one "working" a separate area. In this manner virtually every home in Greendale was canvassed. The number enrolled each month, after the first few months gradually dwindled and the morale of the committee became thin and finally the date of November 1, 1939, was established by the committee as the date the plan either should begin to operate or further efforts should be discontinued. In this thought the Medical Extension Committee of the Medical Society of Milwaukee County concurred. The minimum number established under the plan was met by the committee late in the evening of October 31, 1939. The Greendale Committee had enrolled 201 subscribers. The minimum was 200. An undetermined number of the eligible families in the community were already members of an existing privately owned prepayment sickness insurance plan.

At Park Lawn, the second governmental housing project to which the plan had been offered, the citizens committee after six months of effort to enroll people in the plan advised the Medical Society of Milwaukee County that there was not sufficient interest in the community to make possible the operation of the plan.

The plan as drafted called for the application of the plan in one or more industrial units. Representation has been made to more than one plant, but to date no plant has indicated that it wishes to participate. The Northwestern Railway Employees were at one time considered by the Medical Society of Milwaukee County as possible trial groups, as were the employees of the Milwaukee Journal, the Plankinton Packing Company, the LeRoi Manufacturing Company, the Huth James Shoe Company, the Louis Allis Company and the Chain Belt Company.

II. Services

1. The Greendale community is the only Milwaukee County group that is actually "service-operative." It is to be recalled that under this plan the subscriber is required to pay direct to one of the *participating* physicians the sum of $24 before he becomes eligible for service under the plan. In addition to the payment of the $24 for services rendered the subscriber must have paid his dues regularly to be in good standing.

2. It is not known how many of the 200 subscribers have incurred medical obligations approximating the deductible amount, but certain it is that some are approaching this figure. It is difficult under existing conditions to pull this information together, but the Society is making that effort at this time. It is hoped that some supplementary information may be available to the Council by January 6.

3. Four "units" (families) have become service-eligible under the plan. One unit incurred medical costs in excess of $24 for a hemorrhoidectomy, another required a hysterectomy, a third a confinement, and a fourth a tonsillectomy.

III. Finances

1. Under this plan, as in the other plans, 20 per cent of the subscribers' dues are earmarked for administrative purposes and 80 per cent for medical fees.

2. The State Medical Society has contributed to the administrative account of the Milwaukee trial the sum of $300, and has paid for other administrative costs beyond the cash contribution. The organization costs exceeded this amount from $100 to $125. This will be paid by the State Society, making a total organization contribution of from $400 to $425. This represents the total organization costs of the trial, all of which have been borne by the State Medical Society. While no actual cash outlay has been experienced by the Medical Society of Milwaukee County for the organization of the trial plan, it made available from time to time the services of its assistant executive secretary, Mr. Ralph Weber, who has executed the wishes of the Medical Extension Committee of the Medical Society of Milwaukee County.

ROCK COUNTY

I. Solicitation

1. The work of enrolling groups in the Rock County plan has been delegated to a special committee of fifteen members of the Rock County Medical Society. This committee meets regularly once each month to consider the means that are open to it for the development and operation of the plan.

2. The plan of the Rock County Medical Society was announced to the public in the newspapers in Rock County on August 16, 1939. One paper gave good space to the story while the other daily paper in the county barely mentioned the announcement.

3. Each of the members of the fifteen-man committee is expected to develop one or more groups that might be interested in the plan. The personal efforts of the committee members have been the only means that have developed any groups that might possibly consider the plan. Many members of the committee have approached personal friends who are either employers or executives in plants that employed sufficient personnel to make the group eligible. Personal calls have also been made to officers of union groups both in Janesville and Beloit.

One group, the teachers' association in Janesville, has considered the plan as a group. This association numbers about 150 to 160 teachers employed in Janesville and immediate vicinity. The president of this association was enthusiastically interested in the plan and attempted to interest the other members of the association. After an intensive effort on his part to interest association members in the plan, the president reported that only about thirty of the teachers were interested. One school found a sufficient number in its group to make it eligible under the plan. This school combined with another represents twelve units or families. A second group, a printing plant with seven employees, has made application for participation. As a result of personal solicitation on the part of members of the Medical Extension Committee over a period of five months there has been enrolled a total of nineteen families.

4. The chairman of this special committee, together with the chairman of the sub-committee on membership, directed some thirty letters to groups and plants advising them that they would be glad to meet with them and discuss the plan with any group or committee that they might designate. No response was received from this effort.

5. The Medical Service Committee of the Rock County Medical Society has considered the advisability of employing one or two insurance salesmen for a short period to see if sufficient groups might be enrolled to make the plan operative. One salesman would be employed to cover the territory in and about Janesville and one in the Beloit area.

6. There is now being considered another promotional effort (a direct by mail effort), taking a sampling of the people in the two major cities in the county, attempting to reach large numbers with information that prepaid medical service can be obtained by groups. To accomplish this would not require a great outlay of money and yet would serve a useful purpose to ascertain, in a different manner, the demand for such service.

II. Services

There have been insufficient numbers (150 families) enrolled to place the plan in actual operation.

III. Finances

1. The Medical Service Committee has intentionally refrained from incurring extensive financial liabilities. No offices have been opened, no employees hired, or other usual office expenses incurred. The committee has felt that until such time as there is an imminent need for such services the Society was not justified in incurring such costs.

2. One administrative contribution has been made by the State Society in the amount of $25. This has been used for the most part to defray the cost of meeting notices, record books and other small necessities. The State Society has advised the Medical Service Committee that if they determine from a policy standpoint that they would like to employ one or more salesmen for a short period, the Society would advance a reasonable amount of money to cover such salary costs.

3. Should the Rock County Medical Society determine upon the policy of a direct by mail campaign, the costs of this work would be borne by the State Society. This would cover such costs as postage, printing, labor and similar costs.

The 1940 Budget

In accordance with the usual procedure, the Executive Committee of the Council met for a day in December to make its recommendations to the Council for the 1940 budget. The data and recommendations so made are presented as an agenda herewith.

Summary

This interim report deals exclusively with matters of current Council concern wherein action is pending. The usual work of the state office in carrying forward committee efforts, the projects of the year, and the normal flow of membership and officer inquiries is not here detailed.

Respectfully submitted,

J. G. Crownhart,
Secretary.

9. Membership Certificates

As a subject affecting the 1940 budget, the matter of a new form of membership certificate was presented by President Arveson, with explanations and use of samples. There was discussion by President Arveson, Secretary Crownhart, and Councilors Jegi, Christofferson, Fitzgerald, Lambert, Heidner and Gramling, Past President Rector, and Vice Speaker Kurten. Upon motion by Krahn–Gramling, the president was instructed to arrange for presentation of this matter in an impressive manner before the 1940 session of the House of Delegates. There was further discussion by President Arveson and Councilors Christofferson, Clark, Fitzgerald and Butler. The motion was unanimously carried.

Councilor Clark moved that the Society give consideration to the matter of changing the form of the certificates to what might be a permanent form, and offering to the membership a suitable frame at cost if the present size of the certificate is changed. Councilor Lambert moved that this wording be added to the original motion; seconded by Past President Rector. Councilor Fitzgerald amended the motion to the effect that the matter be presented to each county medical society before the annual meeting. There was no second. President Arveson suggested and Councilor Heidner moved that the president and secretary be authorized to change the wording and size of the certificate, with frame to be offered at cost, if desirable. There was further discussion by Secretary Crownhart, Vice Speaker Kurten, and Councilor Heidner. Councilors Clark and Lambert withdrew their motions.

10. Special Report on Voluntary Sickness Insurance Trials

Assistant Secretary Larson presented the latest information concerning the voluntary sickness insurance trials, including actions taken the previous evening at a meeting which he had attended regarding the Douglas county experiment.* Discussion followed by Councilors Christofferson, Clark, Heidner, Fitzgerald, Butler, Lambert and Johnson, President Arveson, Past President Rector, Vice Speaker Kurten, Secretary Crownhart and Assistant Secretary Larson.

11. Determination of the 1940 Budget, Based upon Recommendations of the Executive Committee of the Council

Secretary Crownhart presented the proposed 1940 budget of the Society, based upon recommendations of the Executive Committee of the Council, explaining the various items as listed therein. The budget follows:

RECOMMENDATIONS OF THE EXECUTIVE COMMITTEE OF THE COUNCIL FOR THE 1940 BUDGET

Income

The House of Delegates has established the dues for 1940 at $15 with an assessment of $5 for a total of $20 per member. Our membership as of December 27 is 2,426. Having in mind, however, that new members elected after July 1 pay but prorated dues, we use the figure of 2,375 as the basis for the estimated full-pay membership for the calendar year of 1940. This would provide a total income from dues of $47,500.

Budget

I. *Constitutional officers and committees* ($13,150)

1. *President, travel* 500

Acting upon instructions of the House of Delegates (1935), there is authorized the annual appropriation of $500 to assist the president in defraying his traveling, long distance, and other expenses incidental to his office.

2. *Council and committees* 1,750

Because of the increased activities of the Society, the Council meets four or five times a year with its sixteen voting members and four ex officio members. While councilors are entitled to their traveling expenses, actually only those who travel some distance file statements. In addition this appropriation covers the necessary expenses of the meetings of the twenty-five committees of the Society and finally, an allotment of $250 to defray stationery and postage expense of the councilors and committeemen (such as the annual meeting chairman) who are called upon to do a considerable amount of correspondence. It is difficult to keep within the currently allotted total of $1,750. Were all travel expense billed the total appropriation required would be over $3,500.

3. *Books and periodicals* 150

From time to time books or periodicals are issued of great factual and background importance to the councilors and members of certain committees. Recent examples are a publication of the International Labour Office on compulsory health insurance and its operation, and that of Duke University Law School on proposals in the field of medical care. The appropriation represents approximately but half that expended in 1939.

4. *Delegates to the A.M.A.* 450

Wisconsin has three delegates to the American Medical Association. Some years ago a delegate had approximately half of his time free to attend scientific sessions and at that time the State Society paid rail and pullman fares only. In recent years, the work of the delegate body has kept it in substantially continuous session for four days with reference committee assignments to be filled in off hours. The Executive Committee (the chairman not participating) feels strongly that from now on the Society should reimburse the delegates for their full actual expenditures. In 1940 the A.M.A. will meet in New York City and the budget figure permits of expense accounts up to $150 per delegate.

5. *Auxiliary* 100

The Auxiliary receives an exceedingly limited income from its members (25 cents). It is occupying an increasingly important position with its now 1,200 members and for the past four years there has been an appropriation of $100 to assist the four principal state officers of the Auxiliary in defraying their postage and stenographic expense.

6. *Secretary, salary* 9,000

The salary of the secretary was established on January 1, 1936.

7. *Secretary, travel expense* 1,200

The secretary is reimbursed, within whatever limit is established by the budget, for the actual expense necessitated by official travel. In 1940, a non-legislative year, travel will include speaking engagements before lay groups within the State, district and county meetings in considerable number, committee meetings usually held in Milwaukee, the A.M.A. which he has been unable to attend for three years, the annual national Secretaries' Conference, and like official and important sessions. The budgeted item will not permit of acceptance of all invitations.

II. *Staff* ($9,420)

(Note)—It is to be recalled that one employee left our service to be married prior to the annual meeting, whom we did not replace. A second was dropped by action of the House. This means that the general office staff has been reduced by one-third for 1940.)

8. *George B. Larson, assistant secretary, salary* 3,000

The present salary of the assistant secretary was established on July 1, 1938.

* Description of this meeting published in the Feb., 1940, issue of the Wisconsin Medical Journal, pp. 134 et seq.

9. *Assistant secretary*, normal travel 300
This covers travel to meetings of the Council and for certain standing committees.

10. *Lucia Stolp*, salary 1,800
Miss Stolp came to the Society from the Mayo Clinic in May, 1936. She has general charge of the office, supervising in particular all purchases of supplies and office expenditures. She takes most of the secretary's dictation. Her present salary was established on July 1, 1938.

11. *Hayden Smith*, salary 1,800
Mr. Smith has court reporter abilities and has traveled the State with the Committee on Distribution of Sickness Care and Health Services and the Committee on Hospital Insurance. He takes all legislative hearings on public health matters, proceedings of the committees that must be reported, and assists in the contact and study work with state officers and departments at Madison. The present salary is $145 and the figure listed represents a $5 a month increase.

12. *Helen Brandt*, salary 1,260
Since Miss Ripley left the Society in September, Miss Brandt has full charge of the membership records which, with press service and proof reading, fully occupies her time. Her present salary was established on July 1, 1939.

13. *Ethel Wichern*, salary 1,260
Miss Wichern is stenographic assistant to Mr. Larson and the salary listed represents an increase of $5 a month.

(Note as to salaries—Salaries paid state employees in Madison tend strongly to establish levels difficult to meet. Furthermore, state employees not only receive the usual vacation periods but also are allowed to accumulate sick leave at the rate of three weeks per year. Overtime is required rarely in the state service but with frequency in your Society office due to the very nature of our effort. Your secretary feels that the Society has an employee staff of unusual merit and faithfulness at a salary range under that of the state service.)

III. *Administrative expense* ($6,960)

14. *Accounting and Insurances* 750
This item includes the sum of $200 for extra part-time help required in certain emergencies and during vacation periods, the part-time services of the bookkeeper for the books of the secretary and treasurer, the cost of the annual audits, and the various insurances carried by the Society such as fire, Workmen's Compensation and public liability.

15. *Social Security taxes* 600
The Society has been ruled subject to the Social Security laws and is complying with the Wisconsin Unemployment Compensation Law. This appropriation is fixed in its nature.

16. *Insurance on secretary* 250
The Society carries an insurance policy on the life of the secretary in favor of the Society, in the amount of $10,000. This policy has been carried for five years, with a current premium of $250.

17. *Office*

A. *Rent* 1,810
The present quarters were secured with approval of the Council to reduce the fire hazard of irreplaceable and invaluable records in an old building. Insurance costs have been reduced by more than 50 per cent, indicating that the fire hazard in the old quarters was real.

B. *Telephone and telegraph* 600
This represents a reduction from the 1939 expenditures of 20 per cent.

C. *Supplies* 450
This item covers mimeograph stencils, mimeograph paper, second sheets, typewriter ribbons, and like items of normal office requirements.

D. *Postage and printing* 1,800
The printing referred to is essentially stationery. The postage bill of a normal outgoing mail of fifty pieces, first class, per day, seems to be an irreduceable item. In addition, this item covers the membership certificate mailing, correspondence and postage for our bulletins to committees and officers.

E. *Fixtures and upkeep* 400
The Society finds it essential to purchase a file, and sometimes two, a year; to replace one typewriter of seven; and to provide for repair of others; and like incidental expenses of normal upkeep.

F. *Miscellaneous* 300
In the statement of the budget figures above, the minimums have been used. Each year, however, finds us confronted with situations, emergent in their nature, requiring either a wholly new and unanticipated expense or over-the-budget expenditures. An example, for instance, will be a year when five bulletins to members, costing $600 instead of the budgeted $450, are required. This item is to permit a leeway to this limited extent.

IV. *Membership special services* ($6,750)

A. *General*

18. *Legal* 1,200
This item represents a reduction of 33–1/3 per cent as compared to the 1939 budget and will require denial of a very considerable service heretofore rendered.

The State Society prepares contracts between county medical societies (where arrangements can be made) and local relief authorities for provision of sickness care for those on public assistance rolls. These contracts are in accordance with the charter law of the Society and must be in a form approved by the Council of the State Medical Society and actually bear the signature of the secretary of the Society. The State Society is frequently called upon by county societies to advise them as to membership rights and related questions. Officers of the State Society themselves frequently must resort to legal counsel in order to safeguard the general policies of the Society and further work carried on under this

appropriation includes advice to members concerning problems which affect the profession at large, assistance in interpretation and participation under various relief laws, analysis of other laws peculiarly affecting the profession of medicine, and compilation of Blue Book material.

19. *Special bulletins to members* ---------- 450
With a membership of 2,426, a single special bulletin to the members costs close to $150. The cost of compiling our annual open panel list, paid out of this appropriation, is in excess of $200.

20. *Blue Book issue* ---------- 600
This represents but the excess printing and mailing costs for this annual issue of the Journal.

B. *Scientific*

21. *Annual meeting* ---------- 1,800
This represents the cost to the Society over exhibit income. (See secretary's report on 1939 itemized costs for further discussion and details.)

22. *Graduate centers* ---------- 900
This item was voted by the Council in December, 1939.

23. *Wisconsin Medical Journal* ---------- 1,800
(See secretary's report for discussion and itemized report of 1939 financial experience.)

V. *Public Health, special services* ($7,810)

A. *Normal service* ($4,110)

24. *Hygeia* ---------- 250
This is authorized as a standing appropriation to present at Christmas time, a year's subscription to all state officers, the nine state teachers' colleges, and certain others which have to do with public health problems and procedures.

25. *Press* ---------- 460
This item represents the printing, paper and postage costs of furnishing a weekly story on health and its further attainment, to weekly and daily papers of the State.

26. *Lay publications* ---------- 450
Item represents cost of furnishing health studies, documents and pamphlets to state officers and others who have to pass upon health procedures.

27. *Bulletins to members* ---------- 500
Cost of bulletins dealing with proposed changes in public health laws and rulings

28. *Special reports in the Journal* ---------- 250
Supplements or insert sections dealing with state and national health problems.

29. *Telephone and telegraph* ---------- 450
Dealing with health legislation.

30. *Services, general counsel* ---------- 1,750
Analyzing all legislation to ascertain which deals with health subjects, compiling of data concerning legal effect of changes proposed, and assisting in discussion with and in official bodies.

B. Voluntary sickness insurance trials ($3,700)

Item of Expense	1939 Expenditures (11 months)	Budget 1940
Legal Fees ----------	$ 847.50	000.00

This item covered the cost of extensive legal research that was required before the actual preparation of legal agreements could be made. The legal fees also include the actual drafting and typing of numerous redraftings that were necessary in order that the wording and the items included in the agreement would state precisely the intent and the provisions which the county medical societies wished to have included, and in some instances the items which the lay groups wished to have included.

31. *Printing* ---------- 394.68 $ 300.00
This includes the cost of having special reporting forms made up for each of the trials. From these forms will be obtained the information upon which the trials to a large extent will be judged. These forms were furnished by the State Medical Society in order that they might be uniform throughout and the experience obtained from all of the trials might be combined. This includes furnishing to the several trials history forms that were obtained from each applicant who wished to participate in the trials. This also includes the printing of tabulating cards and the rental of punch card machines, one located in Superior, and the other located at the Medical Society of Milwaukee County. There are also some miscellaneous printing charges that are included in this item, such as survey cards used to send to a cross section of the public in Douglas County.

32. *Grants in Aid to Trials* ---- 1,037.60 2,000.00

Superior ----------	$700.00
Milwaukee ----------	300.00*
Rock County -------	37.60

Allowances are made to those administering the trials for grants to assist in meeting overhead charges. The Society recognized in approving the trials that such grants would of necessity have to be made inasmuch as the trials were starting and, secondly, because of the limitation

* An additional payment of $120.07 will be made January 3, 1940.

which was placed on the number that could enroll, both by the House of Delegates and by the Advisory Committee on Voluntary Sickness Insurance. These funds have been used to assist in paying clerical help, rent, telephone, printing, etc., in each of the trials.		
33. *Travel*	1,293.53	900.00
This covers the travel expense of Mr. Larson for the year necessitated by the trials and research. The reduction in the allowance made for 1940 is based upon the fact that the trips to Superior will not need to be as frequent as they were during the formative period of the trial, which necessitated frequent and sometimes long trips to Superior.		
1939 Preliminary Report of the Advisory Committee		
Printing costs	573.51	
Office Costs	116.41	
In this item are included miscellaneous office expenditures throughout the year.		
34. *Analysis, Recording, etc.*		500.00
It is anticipated that it will be most essential to make a thorough study of the facts which are recorded on the punch cards which are made up each month in each of the trials before the committee will be able to make its report to the 1940 House of Delegates. It is further anticipated that advice, assistance and counsel may be required to assist the advisory committee in interpreting the findings and in making its report to the House. This item will include rental of machines, etc.		
	$4,263.23	$3,700.00

Summary of Budget as Recommended by Executive Committee

Income from dues	$47,500
Recommended budget	44,090
Unappropriated	3,410
The president has a special recommendation as to a new six year form of membership certificate which will be submitted to the Council for consideration. If adopted this would call for an initial appropriation of $875 with a subsequent reduction to an annual cost thereafter of $250. If this appropriation is made a budget figure will be entered of	875
And in that event the unappropriated balance would be	$ 2,535*

* To this will be added whatever interest is realized from bonds in the general fund account. At present these have a face value of $9,000 with $3,000 uninvested. Presumably the interest will be somewhat in excess of $300 for the year but probably not more than $400 at the maximum. By reason of its uncertainty and small amount it has not been set up as a portion of income but is mentioned that its approximate amount may be known.

Discussion of the budget was participated in by all councilors and officers. It was moved by Krahn–Rector that the president's travel allowance be increased from $500 to $750 per annum. The motion was defeated.

After discussion, it was moved by Krahn–Christofferson that the Executive Committee be authorized to decide upon the status of salaries of the general office staff of the Society during the year. Motion carried.

Upon motion by Christofferson–Butler, the budget as a whole was adopted unanimously.

12. Election of Life and Honorary Members

A. *Honorary Membership*

Upon motion by Pippin (by letter)-Rector, Mina B. Glasier, M. D., Bloomington, was voted honorary membership in the State Medical Society in recognition of thirty-five years' devoted duty as secretary of the Grant County Medical Society.

B. *Life Membership*

Upon motion by Blumenthal-Butler, the following were approved as recipients of life memberships in the State Medical Society of Wisconsin: Dr. Gustave Windesheim, Kenosha; Dr. John G. Meachem, Racine; Dr. W. W. Gregory, Stevens Point; Dr. I. D. Mishoff, Milwaukee.

C. *Life Membership*

Upon motion by Christofferson-Krahn, life membership was voted for Dr. H. G. Hinckley, Merrill.

Upon motion by Clark-Jegi, life membership was voted for Dr. W. G. Gnagi, Sr., Monroe.

Upon motion by Bowen (by telegram)—Fitzgerald, life membership was voted for Dr. Phillip A. Panetti, Hustisford.

Upon motion by Councilor Heidner, variously seconded, remittance of dues was voted for Dr. William Van Zanten, Sheboygan, in lieu of life membership for which he was not eligible.

13. Report of the Executive Committee of the Council on Hospital Insurance

The Council received the report of the Executive Committee, discussed it, and acted on it.

14. Committee on Industrial Health

Dr. Stanley J. Seeger, Milwaukee, chairman of the Committee on Industrial Health, discussed at length the work of his committee in relation to the pre-employment and employee periodic health examination program of the Wisconsin Industrial Commission. Secretary Crownhart on request then amplified the statements of Dr. Seeger, and discussion followed which was participated in by President Arveson, Dr. Seeger, Councilors Christofferson, Clark, Fitzgerald, Heidner, Lambert, Krahn,

Butler, Gavin and Gramling, Treasurer Sisk, and Past President Rector.

Upon motion by Fitzgerald-Butler, the recommendation that the Society approve of pre-employment and periodic health examination in industry in principle was accepted and the Committee on Industrial Health was given the authority to select six physicians, whose names would be submitted to the Industrial Commission to constitute medical representatives on an advisory committee. After further discussion, it was moved by Rector-Heidner that to the committee of six physicians be added the president, chairman of the Council, and the secretary if and when problems arise which would make their attendance advisable. Motion carried.

15. Communication from the Orthopedic Section

Dr. W. P. Blount, Milwaukee, as temporary secretary of the Orthopedic Section, read and discussed the following resolution which was unanimously adopted by the Orthopedic Section on November 10, 1939:

"The orthopaedists for the field clinics of the Crippled Children Division of the Bureau for Handicapped Children should be selected in rotation from an alphabetical list of all of the members of the State Medical Society who are certified by the American Board of Orthopaedic Surgery, with the understanding that any orthopaedist, by refusing to go, automatically places his name at the bottom of the list."

Upon motion by Butler-Rector, the above resolution was adopted by the Council for the State Medical Society. Discussion followed by Past President Rector, Dr. Blount, and Councilor Gramling.

16. Designation of Hospitals Approved by the American College of Surgeons for Cancer Treatment as "Cancer Clinics"

After discussion of this subject by Secretary Crownhart and members of the Council, it was moved by Jegi-Heidner that the matter be referred to the proper official body of the American Medical Association for further deliberation. Motion carried unanimously.

17. Amendment to Constitution and By-Laws

Secretary Crownhart read and explained three suggested amendments to the constitution and by-laws, as follows:

1. *Amend Article II of the Constitution,* "Purpose," striking out the words "to guard and foster the material interests of its members and protect them from imposition.

2. *Amend Chapter XI of the By-Laws, Sec. 3.* referring to eligibility of physicians for membership in a county medical society so as to add the italicized words and repeal the word "to" in the sentence that follows: "Every reputable and legally qualified physician who is a citizen of the United States and who is a bona fide resident of the same county shall be eligible *to apply for* (to) membership so long as___ etc.____."

3. *Add a final sentence to Section 3* to read: "A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the Society in whose jurisdiction his principal practice shall have been removed."

Upon motion by Rector-Clark, Secretary Crownhart was authorized to prepare these amendments for introduction at the 1940 session of the House of Delegates.

18. Open Panel Agreement

Secretary Crownhart explained that requests have been made for listings on open panels under other classifications than those currently permitted by the insurance carriers and employers, and said the wishes of the Council were desired by the conference committee on this subject. There was discussion by Secretary Crownhart, Past President Rector, and Councilors Krahn and Heidner. Upon motion by Fitzgerald-Heidner, the sense of the Council was taken to be that the open panel should continue in its present form so far as classification of physicians is concerned. Motion carried unanimously.

19. Committee Appointments by Chairman of the Council

Chairman Gavin made the following committee appointments:

Executive Committee of the Council: Dr. W. T. Clark, Janesville, to succeed Dr. J. W. Lambert, Antigo, who asked his release; and Dr. A. H. Heidner, West Bend, and Dr. Robert W. Blumenthal, Milwaukee, to succeed themselves; plus the president, chairman of the Council, secretary and treasurer, who make up the balance of that committee.

Auditing Committee of the Council: Dr. G. W. Krahn, Oconto Falls; Dr. A. H. Christofferson, Colby; and Dr. Robert W. Blumenthal, Milwaukee, to succeed themselves.

Committee on Open Panel Agreement: Dr. R. P. Sproule, Milwaukee, and Dr. T. J. O'Leary, Superior.

Committee on Wisconsin Hospitals and Medical Payments Plan: Dr. C. H. Andrew, Platteville, and Dr. J. W. MacGregor, Portage, to succeed themselves.

20. Budgeting of Special Recurring Items

Secretary Crownhart explained the present policy of budgeting certain recurring items at the time of their recurrence, and the advisability of budgeting these monthly so that the large sum involved will not seriously affect the budget of one period while having no effect on other periods. Upon motion by Rector-Christofferson, the suggested procedure was adopted as the future policy of the Society.

21. Papers Executed by Physicians for Insurance Companies

Secretary Crownhart read and explained a statement adopted by the Ohio State Medical Association, reading as follows:

"Inasmuch as there has been some confusion in the minds of members of the medical profession and representatives of insurance companies with respect to the charging and payment of fees for services rendered by physicians in providing information to insurance companies, the Council of the Ohio State Medical Association offers the following statement of policy to guide members on this matter:

> Insurance blanks and papers which a physician may be called upon to execute at the request of insurance companies or the insured should be classified as follows: First, those for the benefit of the insurance company; and second, those for the benefit of his patient (or claimant).

The Council believes that a physician is justified in charging an insurance company for the filling out of papers furnished by the company in cases where such information is for the benefit of the insurance company.

With respect to the second class of insurance papers where the information is for the benefit of the patient (or the claimant), the Council believes that the question of whether or not a fee should be charged the patient (or claimant) for such services is one involving physician-patient relationship and that the final decision rests with the physician."

Upon motion by Blumenthal-Lambert, the above statement was adopted as that of the State Medical Society of Wisconsin. Discussion by Councilors Heidner and Blumenthal, and Past President Rector preceded the motion.

22. "M-Day" Arrangement

Secretary Crownhart discussed the action of the Indiana State Medical Association in creating a special committee to cooperate with military and civil authorities with respect to an unhurried and effective program in supplying the medical needs of the military force and securing proper medical care at home in the event that "M-Day" should ever become an actuality.

Upon motion by Fitzgerald-Christofferson, the chairman was authorized to create a special committee of three persons with the secretary as an ex officio member, to constitute such a body. There was discussion by Councilors Lambert and Christofferson, and Secretary Crownhart.

Chairman Gavin appointed Councilors Fitzgerald, Lambert and Blumenthal to constitute this committee, with Secretary Crownhart as an ex officio member.

23. Limitation of Malpractice Policies

Secretary Crownhart stated that one company has placed a limitation on its policies of $5,000 to $15,000 protection. He distributed mimeographed copies of correspondence on this subject and stated that the matter would be scheduled as an order of business at the next Council meeting.

24. County Contracts for Care of the Indigent

Approval of these contracts by the State Medical Society is necessary, Secretary Crownhart stated, and the secretary's authority to approve these contracts in the name of the Society must be made a matter of record to avoid possible misunderstandings in the future. Upon motion by Rector-Butler, the secretary was authorized to follow this procedure in the name of the Society, by unanimous vote.

The meeting adjourned at 4:00 p. m.

Society Proceedings

Ashland—Bayfield—Iron

Six guest speakers from Duluth, Minn., featured the program of the Ashland–Bayfield–Iron County Medical Society meeting on January 31 at the Menard Hotel, Ashland. They were Drs. Charles Mead, W. D. Coventry, Russell J. Moe, Gage Clement, Samuel H. Boyer, Jr., and Arthur H. Wells. Case reports and lectures on blood dyscrasias, cesarean section, and pulmonary fibrosis were presented by the visiting physicians. Thirty-three attended the meeting.

Brown—Kewaunee—Door

A symposium on diseases of the chest was the main feature of the February 8 meeting of the Brown-Kewaunee-Door County Medical Society at the Beaumont Hotel, Green Bay. Dr. J. C. Colignon, Green Bay, led the discussion with a presentation, "Interesting Cases at the Hickory Grove Sanatorium." Other case reports were given as follows:

Congenital Heart Disease—Dr. P. F. Dockry, Green Bay

Diaphragmatic Hernia—Dr. A. H. Brusky, Green Bay

Lung Abscess—Dr. N. M. Kersten, De Pere

Acute Cardiac Failure—Dr. G. M. Shinners, Green Bay

Cook County Hospital Cases—Dr. S. M. Mokrohajsky, Green Bay

Forty-five physicians attended the meeting and the dinner which preceded it.

Columbia—Marquette—Adams

The Columbia–Marquette–Adams County Medical Society held a joint meeting with the Sauk County Medical Society at St. Savior's General Hospital, Portage on February 20. Dr. W. S. Middleton, dean of the University of Wisconsin Medical School, was the guest speaker. Thirty-five attended the meeting. Guests included physicians from Columbus and Baraboo.

Dane

The Dane County Medical Society met at the Madison Club, February 13, for dinner and a scientific program. The guest speaker of the evening was Dr. Waltman Walters, Mayo Clinic surgeon. He talked on the surgical treatment of unusual biliary tract lesions. Also on the program were Dr. Ivan G. Ellis, Madison, who discussed "What's New in Roentgenology," and Dr. Ira R. Sisk, Madison, who spoke on "What's New in Urology."

Douglas

The Advisory Committee of the Douglas County Medical Society met in Superior, February 15, at the Superior Hotel to audit January statements rendered to the Cooperative Health Association by members of the Douglas County Medical Society.

Shown in the picture below are two members of the committee, (reading from left to right) Dr. Victor A. Ekblad and Dr. J. W. McGill, both of Superior. Dr. Arthur G. Wilcox, third member of the committee, was unable to attend the meeting.

Green Lake—Waushara

The January meeting of the Green Lake-Waushara County Medical Society was held at Berlin, January 30, following dinner at the Hotel Whiting with members of the woman's auxiliary. Dr. Merritt L. Jones, Wausau, was the main speaker, discussing "The Intervertebral Discs." Dr. Erwin P. Ludwig, Wausau, attended the meeting as a guest.

Additional officers were elected at the meeting, the complete officers' list now being as follows:

President—Dr. G. G. Mueller, Princeton
Vice-President—Dr. D. M. Regan, Berlin
Secretary-Treasurer—Dr. H. C. Koch, Berlin
Delegate—Dr. A. A. Beck, Wautoma
Alternate delegate—Dr. L. J. Seward, Berlin

Jefferson

Pictured above are members of the special committee of the Jefferson County Medical Society in charge of the spring graduate clinics being presented, April 24–26, under the auspices of the Council on Scientific Work of the State Medical Society. They are (left to right) Drs. H. P. Bowen, chairman; W. S. Waite and T. C. H. Abelmann—all of Watertown. Meeting at the Carlton Hotel, Watertown, on February 8, they made plans for explaining the graduate clinic programs to physicians in the surrounding territory.

The Jefferson County Medical Society held a dinner and business meeting on February 15 at the Black Hawk Hotel, Fort Atkinson. Twenty-four members were present.

La Crosse

On February 13 the La Crosse County Medical Society met at the Hotel Stoddard, La Crosse, for dinner and a scientific program. Dr. J. M. Waugh of the Mayo Clinic, Rochester, Minn., presented a lecture on "Surgical Treatment of Acute Abdominal Emergencies." Fifty members attended the meeting.

Marinette—Florence

Dr. C. H. Boren, Marinette, was the main speaker at the meeting of the Marinette–Florence County Medical Society in Menominee, January 31. He discussed "Respiratory Diseases."

Milwaukee

At the Milwaukee Athletic Club, February 9, the Medical Society of Milwaukee County held its regular monthly meeting. Dr. Charles Fidler, Milwaukee, spoke on "The Interpretation of Sutures and Suture Materials" and Dr. F. A. Coller, professor of surgery, University of Michigan Medical School, Ann Arbor, discussed "The Diagnosis of Acute Abdominal Surgical Lesions." Following the program a social hour and a buffet luncheon were enjoyed.

The Medical Extension Committee of the Medical Society of Milwaukee County held a meeting in the county society offices on the evening of February 7. Problems of the county society in the operation of its trial plan for voluntary sickness insurance were reviewed and discussed. Those present included the Milwaukee physicians pictured above: (reading from left to right) Drs. Dexter Witte, W. J. Houghton, William Jermain, and H. J. Dvorak. Also attending the meeting were Mr. James O. Kelley and Mr. Ralph Weber of the Milwaukee county society staff, and Mr. George B. Larson, Madison, assistant secretary of the State Medical Society.

Outagamie

The Outagamie County Medical Society met on February 15 at the Conway Hotel, Appleton. Following a 6:30 p. m. dinner, a scientific program was presented, Dr. J. E. Gonce, Jr., Madison, being the guest speaker. He talked on "Abdominal Pain of Nonsurgical Origin in Children." Thirty-three attended the meeting.

Portage

The Portage County Medical Society met on February 14 at St. Michael's Hospital, Stevens Point. "How is Your Health?" was discussed by Dr. P. N. Sowka, Stevens Point health officer, and recent advances in surgery were described by Drs. W. F. Cowan and Erich Wisiol, Stevens Point. Dr. M. G. Rice of the same city led the general discussion which followed the scientific program. Twenty attended the meeting.

Racine

The Racine County Medical Society held its regular monthly dinner meeting at the Meadowbrook Country Club at 6:30 p. m., February 15. Guest speakers were Mr. James Kelley, executive secretary of the Medical Society of Milwaukee County, who spoke on "Business Aspects of Medical Practice and Medical Societies," and Mr. Ray McPherson of the Associated Hospital Service, Inc., who discussed "Hospital Insurance—the Wisconsin Plan."

Rock

The Rock County Medical Society met at the Hotel Monterey, Janesville, January 23, for dinner and a scientific session. Dr. L. G. Gatewood, clinical professor of Rush Medical College, came from Chicago to give a lecture on "Medical Management of Peptic Ulcers." In a business session, the twenty-eight doctors attending the meeting discussed obtaining reprints of a series of three articles by Paul de Kruif which appeared in the October and December, 1939, and the January, 1940, issues of *The Country Gentlemen*, entitled "The People Demand Public Health."

Sheboygan

The Memorial Hospital, Sheboygan, was the meeting place of the Sheboygan County Medical Society on February 6, at which the society's secretary reports "Mayor Runge (of Sheboygan) cleared up some medical relief difficulties." Dr. R. L. Zaegel, Sheboygan, presented a paper on "Poliomyelitis" and Dr. T. G. Randolph, Milwaukee, spoke on "Food Allergy." Forty physicians attended the meeting.

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo Medical Society met in Whitehall, February 15. Dinner was served at 6:30 p. m., after which the members enjoyed a talk by Dr. R. G. Arveson, Frederic, president of the State Medical Society.

Walworth

The Walworth County Medical Society met at Lake Geneva on February 8. Following dinner, which was enjoyed with members of the woman's auxiliary, members of the society heard a talk by Dr. M. G. Peterman, Milwaukee, on "Infant Feeding." Twenty-four physicians attended the event.

Waukesha

The Waukesha County Medical Society met at the Majestic Hotel, Oconomowoc, February 7. The use of sulfanilamide was discussed on the scientific program by Dr. Francis D. Murphy, Milwaukee.

Winnebago

The Winnebago County Medical Society held a dinner meeting on February 1 at the Athearn Hotel, Oshkosh. The speaker of the evening, Dr. Maurice Hardgrove, Milwaukee, discussed "Peripheral Vascular Disease."

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine met on February 20 for a business and scientific meeting. On the scientific program Dr. F. J. Mellencamp, Milwaukee, discussed "The Allergic Child," and Dr. R. M. Klemme, St. Louis, Missouri, spoke on "Surgical Treatment of Parkinson's Disease and Athetosis." Dr. Elwood W. Mason, chairman of the Academy's program committee, states that Dr. Klemme has obtained startling results in the surgical treatment of muscular dystonias.

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society was host to over twenty members of the Central Wisconsin Society of Ophthalmology and Otolaryngology at a full day meeting in Milwaukee, February 12. Clinics, scientific discussions and case reports were presented at the Milwaukee County Hospital and Dispensary, the United States Veterans' Hospital and the Milwaukee Children's Hospital. Dinner and a social hour were enjoyed in the evening at the University Club.

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society met on February 13 at the Milwaukee Sanitarium in Wauwatosa. Following dinner, served in the Sanitarium's Colonial Hall, members of the society heard talks on the treatment of mental disorders by Dr. L. J. von Meduna, "father of metrazol shock therapy," Loyola University, Chicago, and by Dr. Walter Freeman, professor of neurology, George Washington University, Washington, D. C.

Milwaukee Roentgen Ray Society

At the annual meeting of the Milwaukee Roentgen Ray Society held at the University Club, Milwaukee, February 2, the following Milwaukee physicians were elected officers for the ensuing year:

President—Dr. H. W. Hefke
Vice-President—Dr. F. C. Christensen
Secretary-Treasurer—Dr. Irving I. Cowan

Milwaukee Society of Clinical Surgery

Officers of the Milwaukee Society of Clinical Surgery, installed at its January 30 meeting, are named below:

President—Dr. L. D. Smith, Milwaukee
President-Elect—Dr. R. W. Roethke, Milwaukee
Secretary—Dr. G. S. Flaherty, South Milwaukee
Treasurer—Dr. J. F. Zivnuska, Milwaukee
Directors—Dr. T. J. Gunther, Sheboygan; Dr. Max Bornstein, Milwaukee

(See announcement of the society's March 26 meeting, p. 233.)

News Items and Personals

Dr. Stanley J. Seeger, Milwaukee, will discuss "Pediatric Surgical Problems," at the eleventh annual assembly of the Southeastern Surgical Congress to be held at the Tutwiler Hotel, Birmingham, Ala., March 11–13.

—△—

Four members of the State Medical Society of Wisconsin have been invited to serve on the special committee of the Wisconsin Society for Mental Hygiene to review statutes relative to the care and treatment of the mentally ill and handicapped. They are: *Dr. A. W. Bryan*, Jackson Clinic, Madison, chairman of the State Society's Committee on Mental Hygiene and Institutional Care, and *Dr. H. H. Christofferson*, Colby, a member of the same committee; *Dr. J. S. Supernaw*, Madison, and *Dr. Gilbert J. Rich*, Milwaukee. Dr. Rich will be chairman of the special committee, the objective of which is understood to be the revision of present laws to bring them into harmony with modern standards and practices.

Others invited to serve on the special committee are: Miss Helen Clarke, Miss Harriet Grimm, Mr. Frank Vicroy and Mrs. A. W. Schorger, Madison; Judge Roscoe Luce, Elkhorn; Mr. Chester Zeff, Kenosha; Mrs. Fulton Leberman, Sheboygan; Judge August Braun, Mr. F. Perry Olds, Dr. Samuel A. Kirk and Mr. Edmund B. Shea, Milwaukee. *Dr. H. W. Powers*, Milwaukee, is president of the Wisconsin Society for Mental Hygiene.

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Dr. Irving Auld, Clintonville, spent February 12–17 at the Mayo Clinic, Rochester, Minn., in the graduate study of proctology.

Dr. C. C. Edmondson, who severed his connection with the Waukesha Spa upon the transfer of its ownership, has announced the opening of his own offices at 506 Lincoln Avenue, Waukesha. Dr. Edmondson will limit his practice to internal medicine with particular reference to the field of diabetes and rheumatic diseases.

—△—

Dr. Lindley V. Sprague, 2520 Washington Avenue, Madison, has announced the association with him of his cousin, Dr. John T. Sprague, in the practice of medicine and surgery. Dr. John T. Sprague, a 1935 graduate of the University of Cincinnati College of Medicine, until recently was associated in practice with his father in Athens, Ohio.

—△—

Dr. Harry Beckman, director of the department of pharmacology, Marquette University School of Medicine, has received a grant from the Committee on Therapeutic Research of the American Medical Association in support of his chemotherapeutic studies in mosquito-conveyed avian malaria. *Dr. Armand J. Quick*, associate professor of the department, has received a grant from the Committee on Scientific Research of the Association in support of his studies on the conversion of prothrombin to thrombin.

—△—

Dr. C. F. Cheli, Columbus health officer, discussed health problems in that community on February 6 at a luncheon meeting of the Columbus Women's Club. He stated there has been a notable freedom from contagious diseases in Columbus, a city of about 2,500 population.

Drs. Robert W. Blumenthal, Milwaukee; *Wellwood Nesbit,* Madison; and *C. D. Neidhold,* Appleton—members of the State Society's Advisory Committee on Voluntary Sickness Insurance—met at the Washington Hotel, Watertown, on February 8. Reporting to the committee on the progress of voluntary sickness insurance plans now in operation were *Dr. Dexter Witte,* Milwaukee, chairman of the medical extension committee of the Medical Society of Milwaukee County; *Dr. W. A. Munn,* chairman of the medical service committee of the Rock County Medical Society and Mr. George B. Larson, assistant secretary of the State Society.

Shown in the picture above (left to right) are: *Drs. C. D. Neidhold, W. A. Munn, Robert W. Blumenthal, Dexter Witte,* and *Wellwood Nesbit.*

Members of hospital staffs of Beloit and Janesville, Wisconsin, and Rockford, Illinois, were guests on February 13 at a lecture sponsored by the Beloit College branch of a national honor society for the promotion of research in science, Sigma Xi. The lecture, given by Dr. J. F. Fulton of Yale University School of Medicine, dealt with the subject, "Experimental Studies on Functions of the Frontal Lobes in Monkeys and Man."

—△—

The Milwaukee Children's Hospital will continue in March, April and May the series of noon clinics inaugurated in February. *Dr. Stanley J. Seeger* is chairman of the surgical clinics; *Dr. Walter P. Blount* is chairman of the fracture service and orthopedic clinics; and *Dr. A. L. Kastner* is chairman of the pediatric clinics. Clinicians from Chicago and Madison are assisting Milwaukee physicians with the presentations.

—△—

Dr. Bourne Jerome, 1935 graduate of the University of Minnesota Medical School, has become associated in practice with *Drs. E. A. Myers* and *T. J. Doyle,* Superior, specialists in the treatment of diseases of the eye, ear, nose and throat.

—△—

The Milwaukee county public welfare board on January 25 approved the appointment of *Dr. Michael Kasak,* 55 year old Wauwatosa physician, as medical director of the Milwaukee county asylum for chronic insane and the county hospital for mental diseases. Dr. Kasak, clinical director of the institutions since 1925, has been acting medical director since the retirement a year ago of Dr. A. F. Young.

—△—

Madison and Wisconsin health problems were discussed by *Drs. Milton Trautmann* and *F. F. Bowman,* Madison, before a group of the Madison League of Women Voters on February 5.

—△—

A lecture sponsored by the Racine civic council, was given by *Dr. R. D. Bergen,* Milwaukee, at the Franklin Junior High School of Racine on February 12. Dr. Bergen's subject was "Teachers' Problems in Relation to the Mental Health of Children."

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Dr. Francis D. Murphy, Milwaukee, discussed "High Blood Pressure," at a meeting of the luncheon club of the Milwaukee Knights of Columbus, February 13.

—△—

"Pinch hitting" for Mr. J. G. Crownhart, then in the hospital recovering from an operation for hernia, *Dr. S. E. Gavin,* Fond du Lac, on January 13 discussed the highlights of the Wagner Health Bill and traced the history of socialized medicine at a meeting sponsored by the Twentieth Century Club, Oshkosh. About 200 were present.

—△—

"The Role of the Practitioner," was the subject of an address given before the faculty and students of Marquette University Medical School by *Dr. Fred G. Johnson,* Iron River, on February 7.

Step Toward Perfection

Crude drugs and chemicals procured for the preparation of Lilly products must measure up to highest standards. Assays from outside sources, no matter how reliable, never are accepted without confirmation from the Lilly control laboratories.

Ephedrine Inhalants, Lilly—Ephedrine, topically applied to inflamed nasal mucous membrane, relieves congestion and facilitates drainage.

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INDIANAPOLIS, INDIANA, U. S. A.

One hundred and fifty members of the Holy Name Society of St. Mary's church, Kaukauna, attended a talk given by Dr. Robert T. McCarty, Appleton, February 11, on "The Influence of the Church on Medicine."

—△—

Dr. John M. Dodd, Sr., Ashland, recipient of many honors for his outstanding service to his profession and the people of Wisconsin, was honored again, February 12, when the citizens of Ashland held a testimonial dinner for him. Dr. Dodd began the practice of his profession in Ashland in 1889 and has recorded many of his experiences as a pioneer physician there in an interesting book, "The Autobiography of a Surgeon," published in 1928.

Dr. Dodd, now 73 years of age, was the first secretary of the Ashland County Medical Society; a councilor of the State Medical Society from 1903 to 1930; a member and officer of the State Board of Medical Examiners from 1913 to 1924; president of the board of trustees of Northland College for over twenty-two years; and president of the State Medical Society of Wisconsin in 1912. He received the Council Award of the State Society in 1930. For several years he was mayor of Ashland.

The following letter from *Dr. William S. Middleton*, dean of the University of Wisconsin Medical School, was one of the tributes to the career of Dr. Dodd read at the dinner:

THE UNIVERSITY OF WISCONSIN
Madison
The Medical School

Dr. John M. Dodd, Sr., February 9, 1940.
Ashland, Wisconsin.
Dear Dr. Dodd:

The Ashland Chamber of Commerce honors the community in honoring you. It is a refreshing sign of the times to find such a representative body of your fellow citizens departing from the normal routine to pay homage to one who has given so much of himself to the welfare of his fellow beings.

Your origin in Pennsylvania and your transplantation to northern Wisconsin epitomize a pioneer spirit that has marked you as an unusual physician. When my predecessor, Dean Charles R. Bardeen, instituted the preceptorial plan of instruction for medical students at Wisconsin, you were selected as a representative physician to carry on this venture in northern Wisconsin. You have rendered continued and stimulating service in this experiment in medical education for fifteen years. The University of Wisconsin Medical School wishes to express its deep appreciation of this service and its indebtedness to you among others of this select group that have given unstintingly of themselves for an ideal. In this effort there has been no thought of personal reward; yet from it has come one of the conspicuous contributions to medical education in our time.

May I add to this official word of felicitation my sincere expression of personal esteem and best wishes for your future well-being.

With kind personal regards, I am,
Sincerely yours,
WM. S. MIDDLETON, M.D.,
Dean.

—△—

In observance of National Social Hygiene Day, February 1, several Wisconsin health officers spoke on the treatment of social diseases. In Racine, Dr. W. W. Bauer, director of the Bureau of Health Education, American Medical Association, Chicago, addressed members of the Racine Kiwanis Club on syphilis and its influence on modern life.

—△—

U. S. Pharmacopeial Convention Delegate.—As announced in the December issue of THE JOURNAL, the Council of the State Medical Society will consider appointing as a delegate from Wisconsin any member of the Society who plans to attend the United States Pharmacopeial Convention in Washington, D. C., May 14, 1940. Applications for such appointment should be mailed to the secretary of the State Society, 917 Tenney Building, Madison, not later than March 15.

CORRECTION

In the January issue of The Journal in an article by Dr. A. E. Brown, Mayo Clinic, Rochester, Minn., the intravenous dose of the sodium salt of sulfapyridine (stated on p. 16, eighth line from the top of the right hand column) is erroneously given as 0.6 gm. per kilogram of body weight. The correct dose for intravenous administration is 0.06 gm. per kilogram of body weight. The drug is not available for general use but is supplied only for clinical or experimental investigation.

BIRTHS

A son to Dr. and Mrs. L. J. Seward, Berlin, on January 25.

A daughter, Gail, to Dr. and Mrs. Garrett A. Cooper, Madison, on February 14.

A daughter to Dr. and Mrs. A. H. Fromm, Milwaukee, on January 28.

DEATHS

Dr. Otto L. Bergner, Milwaukee, died at his home on February 14 after an illness of one year. He was 57 years of age and had practiced in Milwaukee for thirty years.

Dr. Bergner was born in Centerville, Wisconsin. He was graduated from the Milwaukee Medical College in 1908 and practiced for two years in Fredonia, Wisconsin, before opening his Milwaukee office.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association. Surviving him are his widow and two sons.

Dr. Horace G. Hilliard, Minong, died on January 27 in a Superior hospital. He had been ill for several months.

Dr. Hilliard was born in Cape Vincent, New York, in 1860. He was graduated from Beaumont Hospital Medical College, St. Louis, in 1891. Before locating in Minong, Dr. Hilliard practiced in Downing and Tomah, Wisconsin. He retired from active practice several years before his death, after twenty years in practice in Minong.

He was a member of the Douglas County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. Surviving the doctor are his widow and one son.

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—its excellent bacteriostatic property;

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SOCIETY RECORDS

New Members

C. H. E. Wheeler, Platteville.

Gail R. Broberg, 108 North Commercial Street, Neenah.

S. R. Beatty, Mercy Hospital, Oshkosh.

R. W. Utendorfer, Prairie du Chien.

A. A. Charbonneau, 320 North Washington Street, Green Bay.

B. C. Kilbourne, 1714 West Bruce Street, Milwaukee.

Mary J. O'Leary, 212 West Wisconsin Avenue, Milwaukee.

F. J. Bongiorno, Albany.

D. M. Calvy, 11 North Main Street, Fond du Lac.

Sylba Adams, Hayward.

C. O. Lindstrom, Route 1, Eagle River.

Marvin Wright, 8A, South Brown Street, Rhinelander.

M. E. Ross, 419 Pleasant Street, Beloit.

F. F. Gollin, La Farge.

G. C. Stone, 223½ Huron Street, Berlin.

Mildred M. Stone, Berlin.

L. W. Nowack, 519 Main Street, Watertown.

R. C. Halsey, Lake Geneva.

J. W. Rastetter, 2430 West Wisconsin Avenue, Milwaukee.

R. R. Crigler, 1217 Milwaukee Avenue, South Milwaukee.

J. F. Dorsch, Amherst.

D. A. R. Morrison, Rogers Memorial Sanitarium, Oconomowoc.

Changes in Address

A. J. Harris, Adams, to Friendship.

M. W. Westermeyer, Oxford, to Fairlee, Vermont.

S. B. Weinstein, Milwaukee, to 2623 S. E. Aukeny, Portland, Oregon.

J. B. Matthews, Milwaukee, to 1321 Serpentine Drive, St. Petersburg, Pennsylvania.

W. H. Adashek, Milwaukee, to 525 North Sixth Street, Apartment 37, Muskogee, Oklahoma.

L. E. Dockry, Kewaunee, to Commandant's Office, Great Lakes, Illinois.

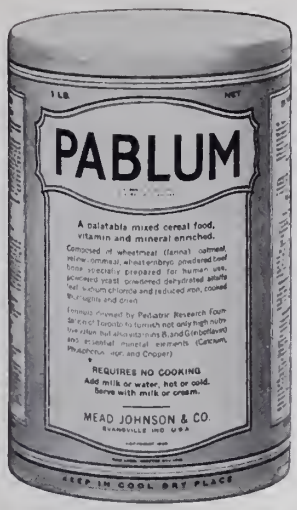
RECENT WISCONSIN LICENTIATES

The following physicians were licensed to practice medicine in Wisconsin after passing the examination given by the Wisconsin State Board of Medical Examiners at the Hotel Loraine, Madison, on January 9, 10, and 11, 1940.

Name	*School of Graduation*	*Year*	*Present Address*
Anderson, Harley A.	Med. Evang.	1939	Hinsdale, Ill.
Bender, Dorothea A.	Marquette	1939	2215 Glenwood, Minneapolis, Minn.
Cook, Edw. T. Jr.	Oklahoma	1939	925 Mound Street, Madison, Wis.
Davis, Richard R.	Pennsylvania	1938	Wisconsin State San, Statesan, Wis.
Faber, William M.	Wisconsin	1938	Wisconsin General Hospital, Madison, Wis.
Glenn, Everett C.	Wisconsin	1937	814 W. Dayton Street, Madison, Wis.
Greeley, David M.	Harvard	1937	1717 Kendall Avenue, Madison, Wis.
Hausmann, Paul F.	Northwestern	1939	929 Cedar Street, West Bend, Wis.
Huebner, Jewel S.	Wisconsin	1938	612 East Third Street, Duluth, Minn.
Jackson, Reginald H. Jr.	Northwestern	1936	415 North Carroll Street, Madison, Wis.
Jeronimus, Henry J. Jr.	Minnesota	1938	Osceola, Wis.
Kanzler, Reinhold	Oregon	1938	Wisconsin General Hospital, Madison, Wis.
Ludmerer, Sol	Illinois	1936	904 West Adams Street, Chicago, Ill.
Pelkey, George L.	Rush	1938	Presbyterian Hospital, Chicago, Ill.
Pohle, Herbert W.	Wisconsin	1937	Wisconsin General Hospital, Madison, Wis.
Rogers, Sion C.	Wisconsin	1937	Wisconsin General Hospital, Madison, Wis.
Schrank, Raymond E.	Wisconsin	1938	103 North Randall, Madison, Wis.
Schuele, James M.	Marquette	1939	845 North Twenty-ninth St., Milwaukee, Wis.
Shutkin, Manfred N.	Northwestern	1937	606 West Wisconsin Ave., Milwaukee, Wis.

The following physicians were granted licenses through reciprocity:

Name	*School of Graduation*	*Previous Address*	*Present Address*
Barnes, Haldor	Univ. of Copenhagen Denmark	U. S. Federal Health Service	1395 Main Street, Marinette, Wis.
Cameron, Eugenia S.	Johns Hopkins	Maryland	114 Breese Terrace, Madison, Wis.
Cordes, Victor J.	St. Louis	Missouri	1411 Wauwatosa Avenue, Wauwatosa, Wis.
Covell, Kermit W.	Indiana	Indiana	114 West South Street, Angola, Ind.
Ellis, James C.	Illinois	Illinois	Rockton, Ill.
Gage, Maxwell	Illinois	Illinois	Box A, Wauwatosa, Wis.
Gaynon, Irwin E.	Illinois	Illinois	100 East Jeffery Street, Kankakee, Ill.
Genglebach, Robert D.	Tulane	Illinois	104 East Washington Street, W. Chicago, Ill.
Jerome, Bourne	Minnesota	Minnesota	407 Board of Trade Building, Superior, Wis.
McCallen, Albert M.	Northwestern	Illinois	Apple River, Ill.
Meyer, Alvin J.	Minnesota	Minnesota	Zuelke Building, Appleton, Wis.
Sprague, John T.	Cincinnati	Ohio	Athens, Ohio
Wright, Hobart H.	Northwestern	Kansas	University Hospital, Ann Arbor, Mich.
Zemer, Ralph H.	Ohio State	Ohio	Ridgeland, Wis.



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	Mg. per Oz.	
	Iron	Calcium
PABLUM	8.5	221.0
Beets	0.67	6.8
Carrots	0.17	13.1
Peas	0.50	8.0
Spinach	0.70	21.8
String Beans	0.27	14.2
Tomatoes	0.12	3.1

Peas
1/17 as much Fe,
1/27 as much Ca
as PABLUM

Tomatoes
1/70 as much Fe,
1/71 as much Ca
as PABLUM

Carrots
1/50 as much Fe,
1/17 as much Ca
as PABLUM

NOT only does Pablum have a higher iron and calcium content than vegetables but, most important, clinical studies of children have demonstrated that in Pablum these minerals are in available form. Investigations by Stearns and Stinger, Schlutz, and Cowgill show that even such an iron-rich vegetable as spinach did not increase iron storage in the body, in fact, caused a loss in some instances. A factor responsible for this difference may be the higher content of *soluble* iron in Pablum—7.8 mg. per oz. Then, too, the water in which Pablum is cooked (by a patented process) is dried with it, whereas the cooking water of vegetables is usually discarded, with its valuable content of minerals and vitamins. Stearns reports difficulty in feeding spinach in sufficient quantities to affect the iron balance of children. Spinach and other highly flavored vegetables are often difficult to feed. Pablum, on the other hand, is a palatable cereal that can be fed as early as the third month, and for older children it can be varied in dozens of appetizing dishes. Recipes and samples available on request of physicians.

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1/32 as much Ca
as PABLUM

String Beans
1/31 as much Fe,
1/15 as much Ca
as PABLUM

Pablum consists of wheatmeal (farina), oatmeal, wheat embryo, cornmeal, beef bone, brewers yeast, alfalfa leaf, sodium chloride and reduced iron

Spinach
1/12 as much Fe,
1/10 as much Ca
as PABLUM

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(ORGANIZED 1929)

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Public Relations—
Mrs. Ira F. Thompson, Racine
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Mrs. E. Lee Lochen, Waukesha

Our Voice

By MRS. ARNOLD S. JACKSON
Madison

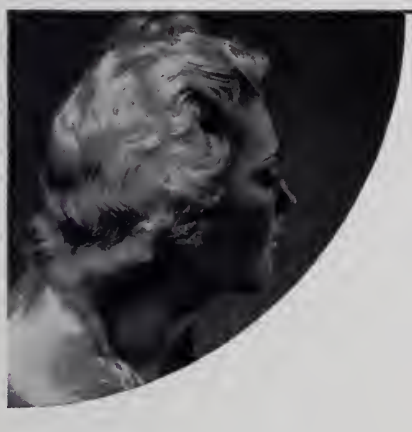
IT IS said that a dog has all the equipment for speaking that is possessed by a man, such as voice box and vocal cords, but a dog seems to lack the urge to express himself. The Woman's Auxiliary of the State Medical Society of Wisconsin has an excellent organ of expression. How happy the Wisconsin organizations of the League of Women Voters, the Federated Women's Clubs, and the Parrent-Teacher Associations would be if they could have what our Woman's Auxiliary has, namely, abundant space in a well-published monthly magazine and expert editorial assistance, all without even the cost of postage!

How can we make the best use of our section of the WISCONSIN MEDICAL JOURNAL? We can use it first of all to get acquainted. So far this year we have had the opportunity of getting acquainted with the president of the State Medical Society, Dr. R. G. Arveson, and with the president of the American Medical Association, Dr. Rock Sleyster. Through these pages we can also get acquainted with the leadership, aims, and activities of our state organization, then with the activities and leaders of the various county societies, and finally with individual members whose goings and comings, marriages, and "blessed events" are included in our news items.

Through the Auxiliary section the leaders of our organization can reach us individually and directly with advice, encouragement, and requests for help in carrying out the purposes of our organization.

In these pages our sponsor, the State Medical Society, through its president, Dr. Arveson, has recently asked us: (1) to carry the true story of medicine to our associates and clubs, (2) to combat the insidious propaganda about medicine which is being spread daily in women's clubs and other groups, and (3) to safeguard the integrity of the medical profession and the health of the people of Wisconsin.

These are challenging tasks. Each of us will want to help her husband and his society by doing what Dr. Arveson has asked us to do. If we act in a unified, purposeful way we can accomplish almost anything we set out to accomplish. Have you ever stopped to realize what a complete and well-set-up organization ours is? We have national, state, and county officers and committees for carrying out almost any project we might adopt. But to be successful it is highly important that we keep in touch with each other and with our officers in the Auxiliary and in the Medical Society. One of the easiest ways of doing this is through the Woman's Auxiliary section of the Wisconsin



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Medical Journal. It seems essential, therefore, that at each meeting of each county society, five minutes be spent listening to a well-prepared resume of the articles and items which have appeared in the Auxiliary section of the latest Medical Journal. In this way we as a society can learn to make the most effective use of the "voice" which we are so fortunate to have.

Have you seen the booklet "Political Medicine and You"?

It is a keen analysis of the Wagner National Health Bill, presented in a readable, popular form. Here are some quotations from this booklet:

Can politics treat appendicitis?

If you were ill, would you have a better chance of life here or abroad?

Do you want your own doctor or a jobholder?

Why is Washington unhealthier than other American cities?

Comparative figures show that cardiac, diabetic and cancer patients have better chances for life in the United States than in Great Britain and Germany, where government health insurance prevails.

Contrasted with the inefficiency of the Wagner Bill is the thoroughness of the campaign to put it over.

Write for copies of this book; up to 10—free; in larger quantities—one cent per copy, prepaid. Address: The National Committee to Uphold Constitutional Government, 205 East Forty-second Street, New York, N. Y.

Exhibits

A Bouquet of Flowers

By MRS. E. LEE LOCHEN
Waukesha

A BOUQUET of flowers is a symbol of our esteem and affection for the one to whom we present this gift. In Wisconsin there are many working for the public good in preserving and bringing about better health. They have performed and are performing this work in various ways.

We have the biographies of the medical men who have cared for the citizens of our State. We have some of their instruments, books, furniture, saddle bags, and so forth, which were used almost a century ago. We may pay tribute to "the country doctor" of those olden days by using pictures of collections and making posters showing the number and age of the articles. There may be clippings and scrap books pertaining to the early days of medicine and medical men in our counties, which we may use. We have men and women forging ahead in the fields of medicine and surgery today. Let us bestow a bouquet of flowers on the workers in the medical field, the workers of today and yesterday.

As Mrs. Ily R. Beir says, "Summation of the multitude of reports and results, together with the acquirements of perspective in their absorption, is accomplished by the exhibits which are designed to bring such records and examples of results and methods quickly and easily to visitors. From these exhibits lessons of worth may be learned and used so that each state may help others and the national auxiliary may benefit from this increased and better informed activity."*

In the past and present year the auxiliaries, no doubt, have done much in placing Hygeia. A poster showing how many subscriptions have been placed and where, would be interesting and perhaps helpful also to another group of auxiliary members. Auxiliary members have knit sweaters for the Red Cross, sold Christmas tuberculosis seals, made scrap books for childrens' hospitals, and sponsored public health programs. Why not tell of your activities by means of a poster, so that others may benefit from them?

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* Bulletin of the Woman's Auxiliary to the American Medical Association 1, No. 2; 18, paragraph 6 (Jan.) 1940.

If you prefer, you might sponsor a public health poster contest in your schools, and send the poster of the contest winner to me. I shall appoint a committee to judge the posters received, and the three adjudged best, as to the requirements of being small, striking, and educational, will be forwarded to the national convention. And the first ten, including the first three, will be exhibited at the state convention in the fall.

Within the next two months I shall expect to receive many posters so that at the conventions we may present to the fields of medicine and public health in Wisconsin *a bouquet of flowers.*

Dane

The January meeting of the Woman's Auxiliary to the Dane County Medical Society was held at the home of Mrs. G. G. Stebbins, Madison. The assisting hostesses were Mesdames D. L. Williams, Lester McGary, J. A. Hurlbut, C. K. Schubert, and A. W. Bryan. A short business meeting was held, and following this Mrs. H. M. Carter, the program chairman, introduced Mr. G. B. Larson of the State Medical Society office, who gave an interesting talk on hospital insurance.

The hostesses at the luncheon on Wednesday, February 14, at the University Club were Mrs. W. S. Middleton, Mrs. A. S. Jackson, and Mrs. I. G. Ellis. The program included reports of various members on current medical subjects and a discussion of the Wagner bill by Mrs. H. K. Tenney. The talk on "The Doctor's Wife" given by Dr. Rock Sleyster of Wauwatosa before members of the Woman's Auxiliary to the State Medical Society of Wisconsin at the annual convention last September was discussed.

Dodge

The first meeting of the year of the Woman's Auxiliary to the Dodge County Medical Society was held at the home of Mrs. W. H. Costello of Beaver Dam on the evening of January 25. Projects for the year were discussed, and after adjournment of the business meeting refreshments were served by the hostess.

Fond du Lac

At a business session following a 6:30 p. m. dinner on Thursday at the home of Mrs. F. S. Wiley of Fond du Lac, the Woman's Auxiliary to the Fond du Lac County Medical Society decided to distribute twenty subscriptions to Hygeia in the city and county and to sponsor a Girl Scout troop. Mesdames V. A. Toland, chairman, J. C. Devine, W. C. Wojta, S. A. Theisen, and D. M. Calvy were appointed as a committee on this latter philanthropic project.

Mrs. H. E. Twohig, president, presented a report of the mid-year meeting of the Board of Directors

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in Milwaukee. At the next meeting of the Auxiliary the members will work on scrapbooks to be distributed to shut-in children.

The dinner committee for this meeting was composed of Mrs. Wiley, Mrs. H. C. Werner, and Mrs. O. M. Layton. Twenty-eight members of the Auxiliary were present.

Kenosha

Nicholas Magaro showed his movies and talked about his recent trip to Italy at the February meeting of the Woman's Auxiliary to the Kenosha County Medical Society at the Kenosha Hospital Nurses' Home.

A short business meeting was held and refreshments served buffet style, with Miss Eva Randall as hostess. Those who assisted her were Mesdames B. S. Hill, C. F. Ulrich, W. C. Stewart, and C. G. Richards.

Milwaukee

Ninety members were present at the valentine luncheon of the Woman's Auxiliary to the Medical Society of Milwaukee County held on Friday, February 9, at the Pfister Hotel. A ship filled with red and white tulips decorated the speakers' table, and red tulip plants decorated the individual tables.

In observance of the universal day of prayer, Mrs. W. F. Grotjan read a collect for club women. This innovation met with enthusiastic approval, and members voted to have its repetition at subsequent meetings.

The president, Mrs. C. D. Partridge presented Dr. W. M. Jermain, president of the Medical Society of Milwaukee County. He discussed the functions of the Auxiliary and explained how its members could assist the medical society.

Mrs. R. D. Bergen, program chairman, introduced the executive secretary of the Medical Society of Milwaukee County, whose subject "What Every Doctor's Wife Should Know" stimulated and enlightened members on what valuable assistance they would be to the profession.

Mrs. R. E. Fitzgerald, chairman of the study group to discuss medical legislation, invited members to attend the meetings the first Monday in each month. Mrs. M. A. Hardgrove, Hygeia chairman, announced that her committee would hold a rummage sale in April to raise funds for the distribution of Hygeia.

The business meeting followed, and the minutes of the December meeting were read and approved. The treasurer's report was also read. Discussion regarding the revision of the constitution followed. As there was no other business, the meeting adjourned.

New members welcomed into the Auxiliary are: Mesdames J. H. Biller, E. C. Kocovsky, G. A. Kriz, D. W. Orvett, A. A. Presti, and R. Y. Wheelihan.

Polk

The Woman's Auxiliary to the Polk County Medical Society has elected the following officers:

President-elect—Mrs. W. C. Andrews, Frederic
Secretary—Mrs. G. B. Noyes, Centuria
Treasurer—Mrs. L. C. Gilman, Osceola

The new president, Mrs. A. N. Nelson of Clear Lake appointed the following committees:

Program—Mrs. R. G. Arveson and Mrs. K. F. Johnson of Frederic
Hygeia—Mrs. L. O. Simenstad, Osceola
Philanthropic—Mrs. D. A. Maas, Webster
Publicity—Mrs. H. C. Caldwell, St. Croix Falls
History—Mrs. J. A. Riegel, St. Croix Falls

Portage

The Woman's Auxiliary to the Portage County Medical Society met on January 29 at the home of Mrs. M. G. Rice of Stevens Point. After a business session Mrs. W. F. Cowan read "The Doctor's Wife," by Dr. Rock Sleyster. A social hour concluded the evening, and refreshments were served. Mrs. E. E. Kidder poured.

Sheboygan

Prevention as a theme of modern dentistry was the subject of highly interesting and instructive lectures given by Dr. John Hollingsworth and Dr. Ashton Wick on Wednesday afternoon, February 7, before the Woman's Auxiliary of the Sheboygan County Medical Society. The dentists stressed early education of parents and children, mouth hygiene, early examination of children's teeth, and regular periodic examinations as necessary preventive measures. They also pointed out how better health results from sound teeth, free from decay and infection, and discussed the importance of the x-ray in dental diagnosis.

Washington—Ozaukee

The January meeting of the Woman's Auxiliary to the Washington–Ozaukee County Medical Society was held at Richfield, where luncheon was served at the Dickel Hotel. This was followed by a bridge party at the home of Mrs. T. J. Kern.

Mrs. H. M. Lynch, West Bend, the Hygeia chairman, will place twenty-six subscriptions to the magazine in schools and hospitals of the two counties. These are presented as a gift from the Auxiliary.

Mrs. R. S. Fisher, Allenton, the public relations chairman, has a list of excellent speakers, members of the State Medical Society of Wisconsin, who will speak free of charge to any organization requesting them. Some of the subjects on which speakers can be furnished are as follows: "Public Health," "Mental Health," "State and Federal Health Programs," "Sickness Insurance," and "Anti-Vivisection."

Waupaca—Shawano

The Woman's Auxiliary to the Waupaca-Shawano County Medical Society met at Weyauwega on Tuesday, February 6. The regular business meeting followed a one o'clock luncheon which was held at the G. T. Classon Tea Room. Mrs. W. J. and R. K. Irvine of Manawa assisted Mrs. E. A. Weller and Mrs. L. F. Corry of Weyauwega as hostesses. The table decorations were in keeping with Washington's birthday and Valentine's Day. Fourteen members were present.

The committee chairmen reported on the work being done and many phases of Auxiliary work were open for discussion, but no definite plans were made for the present. A motion was made to invite the state president, Mrs. F. W. Pope of Racine, to be the guest at the May meeting which will be held at New London.

Contract bridge followed the meeting, and prizes were awarded to Mrs. L. G. Patterson and Mrs. Sam Salan of Waupaca.

Remember the annual convention in Milwaukee in September. Headquarters: Schroeder Hotel. Mrs. Eben J. Carey, chairman.

A. M. A. WOMAN'S AUXILIARY MEETING IN NEW YORK CITY

Have you made your hotel reservation for the 18th Annual Convention of the Woman's Auxiliary to the American Medical Association which will be held in New York City, June 10 to 14, 1940?

The headquarters are at the Hotel Pennsylvania and we are sure you will not want to miss this convention which promises to be an outstanding one. MAIL YOUR RESERVATION TODAY to Dr. Peter Irving, Housing Bureau, Room 1036, 233 Broadway, New York City.

MEETING ANNOUNCEMENT

The Milwaukee Society of Clinical Surgery will have a joint meeting with the Wisconsin Chapter of the International College of Surgeons on Tuesday, March 26. Operative clinics will be held at the Milwaukee County Hospital in the morning by the members of the staff. There will be scientific programs in the afternoon and evening with Dr. Frederick M. Douglass, Toledo, (president of the United States Chapter of the International College of Surgeons) and Dr. Frank Dickson (past president of the American Orthopedic Association) as guest speakers.

On the committee on arrangements are the following: Drs. G. V. I. Brown, L. D. Smith, Sam Higgins, G. S. Flaherty, and W. J. Carson.

PHYSICIANS WANTED BY CCC

Dr. Joyce A. Albert, CCC District Physician, Pocatello, Idaho, writes that the district is experiencing considerable difficulty in securing doctors for positions as full-time contract surgeons for the various CCC Camps of the district, located in Idaho, Wyoming and Utah. He states the pay of a full-time contract surgeon is $3,200 per annum, and the applicant, to qualify for such a position, must be a citizen of the United States and licensed to practice medicine in some state of the Union. Physical examination is not necessary.

RED CROSS ENROLLING TECHNOLOGISTS

At the request of the Surgeon General of the Army, and in compliance with its policy of cooperation with both the Army and Navy, the *American Red Cross,* as an expansion of its peace-time service for the military forces, has undertaken the enrollment of various types of medical technologists, male and female, who are willing to serve in the medical departments of the Army and Navy, if and when their services are required at the time of a national emergency.

Technologists wishing to enroll for service may obtain further information by communicating with The American National Red Cross, Washington, D. C.

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Self-Insurers Invited to Join Open Panel Agreement

THE open panel agreement made by insurance companies selling workmen's compensation insurance in Wisconsin* and the State Medical Society of Wisconsin, to permit employees eligible to benefits under the workmen's compensation act to have free choice of physicians, has been perfected and operating for the last eighteen months. Recently, self-insuring industrial plants in Wisconsin were invited to participate in the agreement. There are in the state in excess of 200 industrial firms who elect to carry their own insurance and pay to their employees such benefits as may accrue to them as a result of injuries which are compensable under the workmen's compensation act. The insurance companies participating in the agreement write about 90 per cent of the compensation insurance in Wisconsin and the self-insurers represented the only sizable block of insured employees not entitled to free choice of physicians, after the open panel agreement was made.

The self-insurers invited to participate in the agreement were advised of the availability of the services of the conference committee, composed of representatives of insurance carriers and of the State Medical Society of Wisconsin, the duties of which are:

a. Mediating, if possible, those cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary.

b. Mediating, if possible, those cases where it is complained that the insurance carriers have unreasonably interfered with what is properly in the discretion or control of the attending physician.

c. Reviewing any situation in which it is claimed that there has been a violation of medical ethics and, in its judgment, referring any facts relative thereto to the Board of Censors of the County Medical Society.

d. Mediating, if possible, differences that may arise between the attending physician and the insurance carrier relative to remuneration.

e. Hearing any complaints relative to the competency of those serving on such panels and removing their names therefrom if, upon investigation, it is found that such complaints are justified.

With the privilege of being listed on the panels both for the self-insurers under the workmen's compensation act and the insurance companies, there are attached certain responsibilities that all members of the State Medical Society should fulfill as their part of the agreement. Each physician participating under the open panel agreement should furnish to the insurance carrier the reports which are essential to the proper disposition of compensation cases. Upon the reports of the attending physician depend the promptness with which the injured employee is reimbursed for his time loss. Similarly, the members of the Society should, in all instances where it is at all possible without endangering the patient's life, obtain the consent of the insurance carrier for consultation, in order that the consultant may be mutually agreed upon.

Members of the State Medical Society having questions relative to their relationship, either with insurance carriers providing compensation insurance or with self-insurers under the workmen's compensation act, have available to them the advice and counsel of the Conference Committee on Open Panels.

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* A list of these insurance companies (members of the American Mutual Alliance or Association of Casualty and Surety Executives) was published in the May, 1939, issue of the WISCONSIN MEDICAL JOURNAL, pp. 410, 412. Further information about the agreement appeared in the December, 1939, issue of The Journal, pp. 1069–1070.

Great Demand For Poor Relief Laws in December Journal

THE December (blue book) issue of the WISCONSIN MEDICAL JOURNAL had been distributed but a few days when requests began coming in for copies of the summary of Wisconsin poor relief laws printed therein.

Wishing to give relief officials in Wisconsin a comprehensive view and an authoritative digest of these laws, the Division of Public Assistance of the State Department of Public Welfare requested 200 copies for distribution. This circularization, in turn, brought forth further requests for the summary. Representative of the numerous filled requests are those reprinted below:

GRANT COUNTY SOCIAL WELFARE DEPARTMENT
Lancaster, Wisconsin

January 23, 1940.

Mr. J. G. Crownhart, Secretary,
State Medical Society of Wisconsin,
Madison, Wisconsin.

Dear Mr. Crownhart: We have received a copy of the "Summary of Wisconsin Poor Relief Laws Affecting Care of Indigent Sick," and in order to have our visitors aware of these laws, we are requesting four or five more copies.

We feel that this new edition has been developed very carefully, and will be helpful to our department in many ways.

Very truly yours,
(signed) E. BENNETT,
(MRS.) ERMA BENNETT,
Director.

PUBLIC WELFARE DEPARTMENT, RUSK COUNTY
Ladysmith, Wisconsin

January 24, 1940.

Mr. J. George Crownhart, Secretary,
State Medical Society of Wisconsin,
Madison, Wisconsin.

My dear Mr. Crownhart: The State Public Welfare Office has recently sent us a bulletin, "Summary of Wisconsin Poor Relief Laws Affecting Indigent Sick." It is our opinion that the town chairmen would find the bulletin extremely useful. We are wondering if you have a supply of these bulletins which could be passed out to the towns free of charge. If so, we should be glad to distribute the bulletins to our 33 towns, cities, and villages.

Thanking you for your cooperation in this matter.

Very sincerely yours,
PUBLIC WELFARE DEPARTMENT,
G. A. ARMSTRONG, *Director,*
By: CLAIRE LUNDMARK,
Supervising Case Worker.

IRON COUNTY
Office of County Pension Department
Box 4, Hurley, Wisconsin

January 24, 1940.

State Medical Society of Wisconsin,
Madison, Wisconsin.

Gentlemen: A copy of your "Summary of Wisconsin Poor Relief Laws Affecting Care of Indigent Sick" has come to my attention. May I please have a copy? I think it is the most usable presentation of this material that I have ever seen. It will be constantly used for reference purposes.

Thanking you, I am

Very truly yours,
RUTH WALKINSHAW,
Case Work Supervisor,
Public Welfare Dept.

WASHINGTON COUNTY PUBLIC WELFARE DEPARTMENT
West Bend, Wisconsin

January 25, 1940.

State Medical Society of Wisconsin,
Madison, Wisconsin.

Gentlemen: We would be pleased to have you forward to us four copies of your booklet, "Summary of Wisconsin Poor Relief Laws Affecting Care of Indigent Sick, December, 1939, issue. In our opinion this booklet is outstanding and very complete.

Thanking you very kindly for your anticipated, prompt cooperation, we remain

Very respectfully yours,
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By: EUGENE A. BRUMM, *Investigator.*

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Payment For Automobile Accident Cases

DOCTORS in hospitals have in the past experienced difficulties in securing payment of charges for services rendered to patients who have collected damages for injuries sustained in an automobile or highway accident.

To make more certain that hospitals and physicians would be properly reimbursed for their services by those who secured damages from insurance companies, and whose damages were, in part at least, based upon the hospital and medical bills incurred by the injured party, a committee from the State Medical Society of Wisconsin, in conjunction with representatives of the Association of Casualty and Surety Executives and the American Mutual Alliance, effected an agreement designed to facilitate the payment of these charges.

The Wisconsin Hospitals and Medical Payments Plan, which was approved by the Wisconsin Hospital Association, the Wisconsin Conference of Catholic Hospitals, the State Medical Society of Wisconsin, the American Mutual Alliance and the Association of Casualty and Surety Executives, is printed in its entirety in the following paragraphs:

1. **Except as the patient or his lawful representative may otherwise direct, the fundamental confidential relationship between the physician or hospital and patient shall be maintained.** It is recognized that in order properly to submit a claim not only the early details of the injuries suffered must be disclosed, but also the expense which the injured party has incurred. In event of law suit or settlement, disclosure of this information is unavoidable, but the election so to disclose is that of the injured patient, and is his to be exercised. Therefore, when so authorized by the patient, the physician and hospital will supply to the interested insurance company or companies complete information concerning the injuries and prognosis.

2. The obligation incurred by the injured party for necessary medical, surgical and hospital care is one primarily owing to either the physician or hospital. Payments by the insurance company by way of indemnifying the patient therefor should be applied toward the liquidation of such obligation to the extent such funds are available, and to assist therein, the insurance companies will recognize orders on proper forms for reasonable charges upon such funds which ultimately may become payable to the patient or his personal representative. Insofar as possible, the insurance company representatives will cooperate with the hospital and the physician in securing such orders. Where the payment is insufficient to afford satisfaction to all parties concerned, the insurance company will endeavor to pay physicians' and hospital bills on an equitable basis.

3. In order that the insurance companies may furnish the fullest cooperation (and for the hospital's or physician's own proper protection) the physician and hospital shall notify insurance companies promptly of any claim upon which an order has been or may be issued.

4. In event of settlement with a patient who refuses or has failed to sign an order, the insurance company will endeavor to carry out the principles set forth in paragraph two and when this cannot be done will notify the hospital and physician before settlement or if such advance notice is not possible, then as soon thereafter as can be done.

5. The company shall pay any expense incurred by the insured, in the event of bodily injury, for such immediate medical and surgical relief to others as shall be imperative at the time of accident.

6. A Conference Committee of eight, consisting of four insurance company representatives, and four representing the medical and hospital interests is created to mediate disputes and to further cooperation.

Conference Committee:

Mr. E. E. Langworthy, stock insurance companies (chairman).

Dr. C. H. Andrew, Platteville, State Medical Society of Wisconsin.

Dr. J. W. Mac Gregor, Portage, State Medical Society of Wisconsin.

Sister Mary Bernadette, Madison, Wisconsin Conference of Catholic Hospital Association.

Miss Grace Crafts, Madison, Wisconsin Hospital Association.

Mr. C. W. Kroening, Wausau, mutual insurance companies.

Mr. H. J. Schroeder, Stevens Point, mutual insurance companies.

Mr. A. D. Kehoe, Milwaukee, stock insurance companies.

Members of the State Medical Society of Wisconsin desiring to have a copy of the bulletin explaining the Wisconsin Hospitals and Medical Payments Plan may obtain one by writing to the office of the State Medical Society, 917 Tenney Building, Madison, Wisconsin.

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The Journal Bookshelf

A Textbook of Pyretotherapy. By Willa Phillips, R. N. Paper. Price, $2. Pp. 84, illustrated. Ann Arbor, Mich.: Edwards Brothers, Inc., 1939.

Injection Treatment of Hernia, Hydrocele, Ganglion, Hemorrhoids, Prostate Gland, Angioma, Varicocele, Varicose Veins, Bursae and Joints. By Penn Riddle, B.S., M.D., F.A.C.S., assistant professor of clinical and operative surgery, Baylor University, College of Medicine; director of the Varicose Vein Clinic, Parkland Hospital, Dallas, Tex. Cloth. Price, $5.50. Pp. 290 with 153 illustrations. Philadelphia: W. B. Saunders Company, 1940.

Diseases of the Gallbladder and Bile Ducts. By Waltman Walters, B.S., M.D., M.S. in surgery, Sc.D., F.A.C.S., head of section in division of surgery, The Mayo Clinic; professor of surgery, The Mayo Foundation (University of Minnesota); and Albert M. Snell, B.S., M.D., M.S. in medicine, F.A.C.P., head of section in division of medicine, The Mayo Foundation (University of Minnesota). Cloth. Price, $10. Pp. 645, with 342 illustrations on 195 figures. Philadelphia: W. B. Saunders Company, 1940.

Pneumoconiosis (Silicosis): The Story of Dusty Lungs. By Lewis Gregory Cole, M.D., director of silicotic research, John B. Pierce Foundation, New York City, and William Gregory Cole, M.D., New York City. Cloth. Price, $1.00. Pp. 100, illustrated. New York City: John B. Pierce Foundation, 1940.

Fourth Saranac Laboratory Symposium on Silicosis. Edited by B. E. Kuechle, vice president and claims manager, Employers Mutual Liability Insurance Co., Wausau, Wisconsin. Paper. Pp. 379. Wausau, Wis.: Employers Mutual Liability Insurance Co., 1939.

Medical Education in the United States, 1934–1939. By H. G. Weiskotten, M.D., dean, Syracuse University College of Medicine; Alphonse M. Schwitalla, S.J., Ph. D., dean, St. Louis University School of Medicine; William D. Cutter, M.D., secretary, Council on Medical Education and Hospitals of the American Medical Association; and Hamilton H. Anderson, M.D., member of the staff, Council on Medical Education and Hospitals of the American Medical Association. Paper. Pp. 259. Chicago: American Medical Association, 1940.

Preclinical Medicine. By Malford W. Thewlis, M.D., attending specialist, general medicine, United States Public Health Hospitals, New York City; special consultant, Rhode Island Department of Public Health; associate editor, Medical Times (New York). Cloth. Price, $3. Pp. 223, illustrated. Baltimore: Williams and Wilkins Company, 1939.

Shock: Blood Studies as a Guide to Therapy. By John Scudder, M.D., Med. Sc.D., F.A.C.S., from the surgical pathology laboratory of the College of Physicians and Surgeons, Columbia University, and the department of surgery, Presbyterian Hospital, New York City. Cloth. Price, $5.50. Pp. 315, with 55 illustrations and five plates three of which are in color. Philadelphia: J. B. Lippincott Company, 1940.

The 1939 Year Book of Obstetrics and Gynecology. Edited by J. B. DeLee, A.M., M.D., professor of obstetrics, University of Chicago Medical School; chief of obstetrics, Chicago Lying-In Hospital and Dispensary; and J. P. Greenhill, B.S., M.D., F.A.C.S., professor of obstetrics and gynecology, Loyola University Medical School; professor of gynecology, Cook County Graduate School of Medicine; attending gynecologist, Cook County Hospital, Chicago. Cloth. Price, $2.50. Pp. 736, illustrated. Chicago: Year Book Publishers, 1940.

Demonstrations of Physical Signs in Clinical Surgery. By Hamilton Bailey, F.R.C.S. (Eng.), surgeon, Royal Northern Hospital, London; surgeon and urologist, Essex County Council; surgeon, Italian Hospital; consulting surgeon, Clacton Hospital and the County Hospital, Chatham; external examiner in surgery, University of Bristol. Ed. 7. Cloth. Price, $6.50. Pp. 310, with 377 illustrations, some in color. Baltimore: Williams & Wilkins Company, 1940.

Manual of Fractures, Dislocations and Epiphyseal Separations. By H. C. W. S. de Brun, M.D., F.A.C.S., adjunct professor of surgery, New York Polyclinic Medical School and Hospital; associate visiting surgeon, Swedish Hospital, Brooklyn, N. Y.; consulting skeletal surgeon, New York Police Department; late chief of clinic, Reconstruction Hospital, New York City. Cloth. Price, $3. Pp. 468, with 150 illustrations. Chicago: Year Book Publishers, 1940.

Injuries of the Skull, Brain and Spinal Cord. Edited by Samuel Brock, New York University. Cloth. Price, $7. Pp. 632, illustrated. Baltimore: Williams & Wilkins Company, 1940.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

A Symposium on the Blood and Blood-Forming Organs: Addresses given at an Institute Conducted by the Medical School of the University of Wisconsin, September 4–6, 1939. Cloth. Price, $3.50, Pp. 264, illustrated. Madison, Wis.: The University of Wisconsin Press, 1939.

This book contains "A Greeting to the Institute" by Edward A. Birge, president emeritus of the University of Wisconsin, and sixteen scientific addresses on different phases of hematology. The illustrations in black and white are excellent and factual data are made clear by the free use of tables. The papers cover all of the more important conditions affecting the blood and blood-forming organs. Each subject is presented by an outstanding investigator and recognized authority in that particular field. Various aspects of the ever-changing group of blood diseases are reviewed although newer scientific developments, which are clearly reported, are stressed.

The publication is unique in that it is essentially a collection of brief, up-to-date monographs by conspicuous authors on a relatively new medical science.

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This book should serve for some years as an authoritative supplement to ordinary texts and can be highly recommended to those who have the slightest interest in diseases of the blood. F. J. P.

Office Gynecology. By J. P. Greenhill, B.S., M.D., F.A.C.S., professor of obstetrics and gynecology, Loyola University Medical School; professor of gynecology, Cook County Graduate School of Medicine; attending gynecologist, Cook County Hospital, Chicago; editor of "Gynecology" in the *Year Book of Obstetrics and Gynecology* and author of *Obstetrics for the General Practitioner.* Cloth. Price, $3. Pp. 406 with 106 illustrations. Chicago: Year Book Publishers, 1939.

This book has been written by the author for the general practitioner who is unable to avail himself of postgraduate study on the newer phases of gynecology which may be performed in the office.

There is a brief review of history-taking and of physical examination which is followed by a discussion of the various medical entities and minor surgical procedures in gynecology. Therapeutic measures are described. The recent advances in endocrinology are covered adequately.

The final chapter in the book is one on premarital examination and advice which is a worth while addition to a book on this subject.

The book should prove of greater interest and value to the physician practicing gynecology than to the general practitioner. M. J. T.

Anatomical Studies for Physicians and Surgeons. Ed. 9. Published by S. H. Camp & Company, Jackson, Michigan, 1939.

The drawings in this book are excellent. They are so simple that a lay person may get some ideas regarding simple human anatomy. For the medical man it will serve as an atlas, illustrating anatomy that enters into many clinical pictures, and recalling the local anatomy quickly by visual means. The legends are clear and definite. It should be of help to lay people, students, and medical practitioners.

E. R. S.

Nutrition and Diet in Health and Disease. By James S. McLester, M.D., professor of medicine, University of Alabama, Birmingham, Alabama. Ed. 3, entirely rewritten. Cloth. Price, $8. Pp. 838, illustrated. Philadelphia: W. B. Saunders Company, 1939.

The present edition of this book (the third), like all previous editions, is outstanding as a reference book in the field of nutrition. Designed as a complete reference work, it does not supply the needs of the practicing physician but rather serves the dietitian and clinician especially interested in dietetics as the standard text on the subject. The book contains chapters dealing with the dietary management of all types of disease in which this aspect of the condition is of more than passing importance. The information provided is both theoretical and practical, with valuable charts and tables of food values and requirements included. From the standpoint of all those interested in nutrition, with the exception of the practicing physician, this book stands at the top of the list. E.S.G.

Short Stature and Height Increase. By C. J. Gerling. With a foreword by Edward Podolsky, M.D. Cloth. Price, $3. Pp. 159, illustrated. New York: The Harvest House, 1939.

This interesting book contains many practical suggestions for the unfortunate individual who has an excessively short stature, and is sensitive about it. These suggestions are practical, sound and based upon well known facts. Half of the book is devoted to a study of the phenomenon of growth under physiological conditions, and the effect of food, sleep, inheritance, endocrine glands and disease upon these processes.

Of perhaps greatest interest from the practical standpoint, is the discussion of the relationship of posture to height. It is a well known fact that an inch or more in stature may depend upon a good or poor posture, and this whole idea is well and clearly expressed in this book. Rather amusing is the section devoted to psychological hints in relation to stature, in which the short individual is advised as to the type of furniture he should choose, and the kind of wall decoration he should elect to stand near, when in the company of taller individuals.

It will be surprising to many to discover that there really are certain things which a small person may do to increase his size both actually and apparently, since adult stature is ordinarily thought of as a more or less fixed quantity. The book is definitely to be recommended. E.S.G.

The 1939 Year Book of General Medicine. Edited by George F. Dick, M.D., J. Burns Amberson, Jr., M.D., George R. Minot, M.D., S.D., F.R.C.P., William B. Castle, M.D., A.M., William D. Stroud, M.D., and George B. Eusterman, M.D. Cloth. Price, $3. Pp. 848, illustrated. Chicago: The Year Book Publishers, 1939.

The editors state that the purpose of the Year Book is to bring up to date the story of the last year's advances in general practice. This aim is very adequately accomplished. Sulfapyridine in pneumonia, possible new indications for sulfanilamide, a new method of visualizing the liver and spleen, and the management of coronary, leukopenic and hemorrhagic disease, are examples of some of the interesting articles reviewed. The editorial notes, which are frequently interspersed, are always stimulating. A comment quoted from *The Lancet* summarizes the situation well: "Guides are almost indispensable in the maze of medical literature; the Year Book is a competent one." M.L.C.

Medical State Board Examinations. By Harold Rypins, A.B., M.D., F.A.C.P., secretary, New York State Board of Medical Examiners; member of the National Board of Medical Examiners, etc. Ed. 4, revised. Cloth. Price, $4.50. Pp. 488. Philadelphia: J. B. Lippincott Company, 1939.

This is a book written primarily for the recent medical graduate who is a candidate for state or

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are discussed in the opening chapters. Two chapters are of particular importance (1) Hygiene and General Care of the Feet; and (2) Pes Valgoplanus (flat foot). The common flat foot, so ineffectively treated, has been handled very successfully by Dr. Hauser.

The book also covers situations arising in the feet in association with systemic diseases. A chapter on fractures and dislocations of the foot and ankle is also included.

The book gives evidence of a tremendous effort and care in preparation and is an invaluable addition to a physician's active library. The print is easy to read, the illustrations clear and numerous and the paper and binding are very good. H. W. W.

Cancer of the Breast and Cancer of the Uterus. Ed. 2. By Marion E. Anderson, A.B., M.D., Clinton, Ia. Cloth. Price, $3.50. Pp. 106, illustrated. Clinton, Ia.: The Franklin Press, 1939.

This small volume of 102 pages is based upon the observations of the author over a period of twenty-seven years. Obviously, two such important subjects cannot be adequately treated in such a condensed form. The bibliography is quite long and most every statement made regarding etiology, diagnosis and treatment is fortified by some authority on the subject. The illustrations are excellent.

The volume was not written for surgeons, gynecologists or pathologists but would seem to the reviewer to be quite useful for what it was intended; namely, to be read and digested by general practitioners and nurses. The one redeeming quality of the book is that it is logical and very properly condemns the atrocious practices which are sometimes included in the treatment of cancer. J. W. G.

Handbook of Orthopaedic Surgery. By Alfred Rives Shands, Jr., B.A., M.D., medical director of the Nemours Foundation, Wilmington, Delaware; associate professor of surgery in charge of orthopaedic surgery, Duke University School of Medicine, Durham, North Carolina (on leave of absence). In collaboration with Richard Beverly Raney, B.A., M.D., associate in orthopaedic surgery, Duke University School of Medicine. Cloth. Price, $4.25. Pp. 567, illustrated. St. Louis: The C. V. Mosby Company, 1940.

This concise textbook of orthopedic surgery fulfills in an admirable way the need of the medical student and of the general practitioner, for a survey of the fundamental facts and principles of this specialized subject. It is not, and was not meant to be a book where one doing orthopedic surgery could look up the detailed steps of a particular surgical procedure. Because of the limitation of space certain important parts of orthopedic teaching have been omitted, the most important one being the subject of fresh fractures. A companion volume on fractures and dislocations would be necessary to cover the field of this specialty completely. However, to include this subject would be to greatly increase the size of the book. The illustrations are very clear. No photographs or roentgenograms have been reproduced directly; all have been redrawn to emphasize characteristic points; many of the illustrations are original pen and ink drawings. The bibliography of outstanding articles written in English has been revised and completed to July, 1939. This is most useful and valuable. It is a good book for the student. V. C. T.

Tumors of the Hands and Feet. Edited by George T. Pack, B.S., M.D., F.A.C.S., New York City, assistant clinical professor of surgery, Yale University School of Medicine and Cornell University College of Medicine; attending surgeon, Memorial Hospital for Cancer and Allied Diseases. Cloth. Price, $3. Pp. 138, illustrated. St. Louis: The C. V. Mosby Company, 1939.

This monograph which has been edited by Dr. George T. Pack is the result of a symposium on "Tumors of Hand and Feet" which appeared in the January, 1939, issue of *Surgery*. The authors participating in this symposium have had considerable experience with these rather rare tumors, both benign and malignant, and as a result there has evolved sufficient pathological information to form a more rational method of treatment. This information should be of great value to most medical men who see these tumors but infrequently. A. R. C.

The 1939 Year Book of Obstetrics and Gynecology. Edited by J. B. DeLee, A.M., M.D., professor of obstetrics, University of Chicago Medical School; chief of obstetrics, Chicago, Lying-In Hospital and Dispensary; and J. P. Greenhill, B.S., M.D., F.A.C.S., professor of obstetrics and gynecology, Loyola University School of Medicine; attending gynecologist, Cook County Hospital, Chicago. Cloth. Price, $2.50. Pp. 736, illustrated. Chicago: Year Book Publishers, 1940.

The Year Book again thoroughly summarizes the current literature. It deserves a place in the library of everyone who desires to keep abreast of recent advances. R. E. C.

"THE FOUNDATION PRIZE"

The *American Association of Obstetricians, Gynecologists and Abdominal Surgeons*, through its secretary, Dr. J. R. Bloss, 418 Eleventh Street, Huntington, West Virginia, announces the following rules governing the award of its "Foundation Prize:"

(1) "The award which shall be known as 'The Foundation Prize' shall consist of $150.

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(5) "The successful thesis shall become the property of the Association, but this provision shall in no way interfere with publication of the communication in the Journal of the Author's choice. Unsuccessful contributions will be returned promptly to their authors.

(6) "All manuscripts entered in a given year must be in the hands of the Secretary before June 1st.

(7) "The award will be made at the Annual Meetings of the Association, at which time the successful contestant must appear in person to present his contribution as a part of the regular scientific program, in conformity with the rules of the Association. The successful contestant must meet all expenses incident to this presentation.

(8) "The President of the Association shall annually appoint a Committee on Award, which, under its own regulations shall determine the successful contestant and shall inform the Secretary of his name and address at least two weeks before the annual meeting."

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATIONS

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board at the Atlantic City Hospital, Atlantic City, N. J., from Friday, June 7, through Monday, June 10, 1940, prior to the opening of the annual meeting of the American Medical Association in New York City on Wednesday, June 12, 1940. Candidates are requested to note that the dates of the examinations have been advanced one day from those previously announced.

Application for admission to Group A, Part II, examinations must be on file in the Secretary's Office not later than March 15, 1940.

Formal notice of the time and place of these examinations will be sent each candidate several weeks in advance of the examination dates.

Candidates for *reexamination* in Part II must make written application to the Secretary's Office before April 15.

The annual dinner of the Board will be held in New York City on Wednesday evening, June 12, 1940, at the Hotel McAlpin. For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

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PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

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[1] Heninger, B. R., and McHardy, G.: *South. Med. Jour.*, 31:1056, Oct., 1938.
[2] Bodenstab, R.: *Deutsches Arch. f. klin. Med.*, 159:171, 1928.
Schottmüller, H.: *Münch. med. Wchnschr.*, 76:502, 1929.
Schultz, M. P.: *Arch. Int. Med.*, 48:1138, Dec., 1931.

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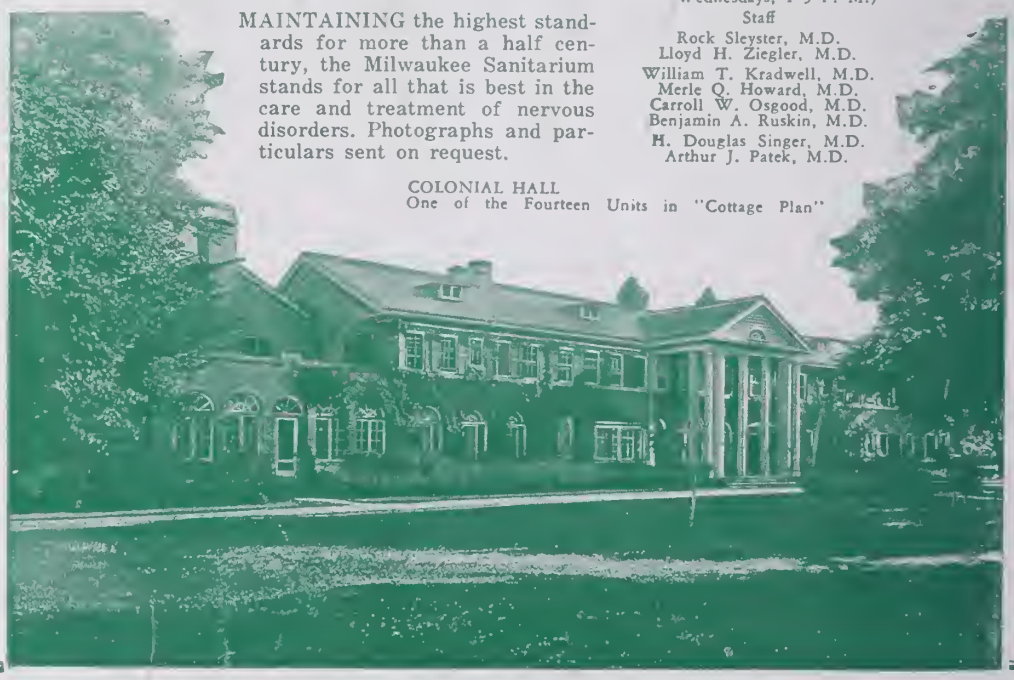

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AMBLYOPIA
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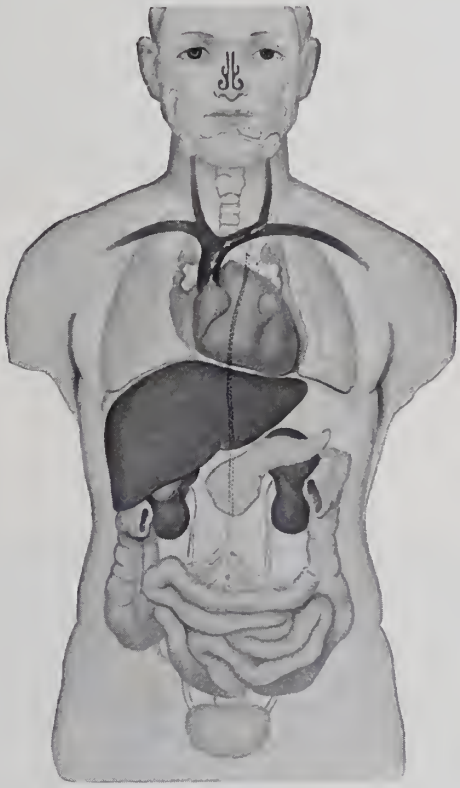
STUDIES IN THE AVITAMINOSES

This page is the fourth of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the April 6 issue of The Journal of the American Medical Association.

Metabolic Fate of Vitamin A and Carotene

Vitamin A and carotene are absorbed into the lacteals with the fat of the food ingested. It is generally agreed that vitamin A in large quantities is more speedily absorbed than are similar quantities of carotene.

The fat-soluble vitamins enter the general circulation by way of the thoracic duct. In the liver, vitamin A and carotene are taken up by the Kupffer cells, where carotene is slowly converted to vitamin A. Experimental studies indicate that vitamin A is stored in the liver in certain species, including man.



The Causes of Vitamin A Deficiency

Vitamin A deficiency may be caused by inadequate intake of the vitamin or provitamin. Absorption may be retarded, depending on the condition of the alimentary tract. For example, mineral oil in the intestine diminishes absorption of carotene although not of vitamin A. Conversion of carotene to vitamin A in the liver may not occur, as in diabetes mellitus, where evidence indicates that the rate of transformation of carotene is diminished, and vitamin A deficiency may develop even if the diet provides the provitamin in amounts ordinarily sufficient.

Effects of Vitamin A Deficiency

Vitamin A deficiency produces pathologic changes in many organs. The process is one of alteration of epithelial surfaces — keratinizing metaplasia of the epithelium of the urinary bladder, the ureters, the ducts of the salivary glands and the pancreas, the trachea, and the nose. In the eye, vitamin A deficiency interferes with restoration of visual purple, resulting in night blindness. Prolonged vitamin A deficiency produces xerophthalmia. Administration of adequate quantities of vitamin A to patients manifesting symptoms of deficiency usually checks the progress of epithelial alteration.

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Vitamin B_6 has been designated biologically as, "that part of the vitamin B complex which is responsible for the cure of a specific dermatitis developed by young rats on the vitamin-free diet supplemented with Vitamin B_1 and lactoflavin" (1). The isolation in crystalline form, chemical identification and synthesis of vitamin B_6 have already been accomplished (2, 3). Chemically, vitamin B_6 is 2-methyl, 3-hydroxy, 4, 5-dihydroxymethyl pyridine. The free base melts at 160°C. and is apparently stable at elevated temperatures.

A recent medical report (4) suggests that vitamin B_6 may be an essential component of the human diet. In one small group of persons it was observed that certain neurological symptoms, which did not respond to treatment with nicotinic acid, riboflavin and thiamin, were distinctly alleviated by the administration of pure synthetic vitamin B_6. This observation is strongly indicative of the importance of vitamin B_6 in human nutrition, and further emphasizes the importance of a varied diet for supplying all nutrients required by the human being.

The distribution of vitamin B_6 in food products has not yet been extensively investigated. However, vitamin B_6 activity has been observed in a variety of natural food materials (5). Hence, it appears that we should continue to rely upon a varied diet to supply our requirements for all components of the vitamin B complex, vitamin B_6 included. The high heat stability of this new vitamin suggests that many foods which commercial canning makes readily available during all seasons of the year may prove to be valuable sources of vitamin B_6, whose essential character in human nutrition seems strongly indicated at this time.

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(1) 1939. The Vitamins, pages 127-140, American Medical Assn., Chicago.

(2) a. 1938. Proc. Soc. Exptl. Biol. Med. 38, 64.
b. 1938. J. Am. Chem. Soc. 60, 1267.
c. 1939. Ibid. 61, 1237.
d. 1939. Ibid. 61, 1242.

(3) 1939. J. Am. Chem. Soc. 61, 1245.

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(5) a. 1936. Missouri Agric. Expt. Sta. Research Bull. No. 241.
b. 1938. Biochem. J. 32, 708.
c. 1938. Indian. J. Med. Res. 25, 879.

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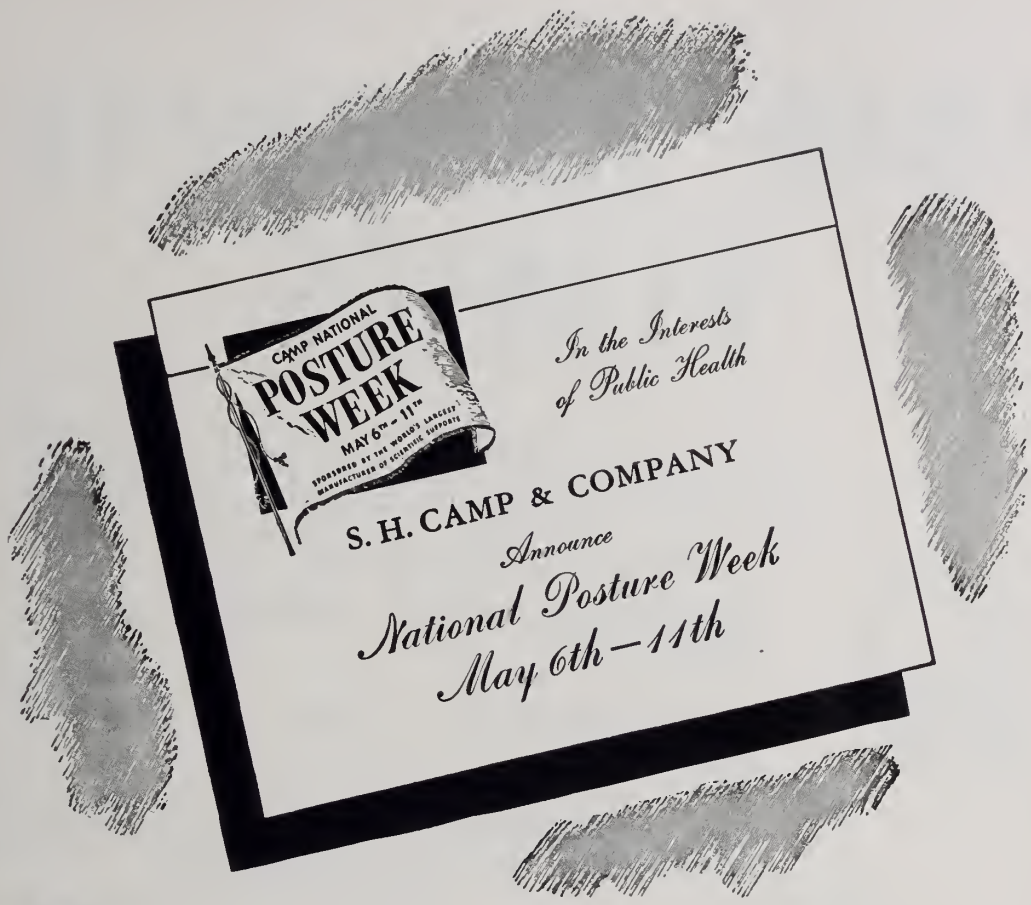

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Mental Medicine Today

By CHARLES F. READ, M. D.
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PHYSICIANS at work deal always with the reaction of the human organism to various stimuli—whether an abnormal state of the liver, lungs, heart, kidneys, or mind, may be most conspicuously in the foreground of the picture at the time. Maladjustment may express itself overtly as asthma, duodenal ulcer, hypertension, or amnesia, but the diagnosis by no means tells the entire story. Whenever we treat a sick person, we deal with a vicious circle, the pathologic status of which cannot be expressed entirely in terms of laboratory and deadhouse findings.

Psychiatry today may be looked on as a somewhat uncertain methodology for the investigation and treatment of human bad-behavior, and, as such, be broadly termed *mental medicine*—the art of diagnosis and treatment applied to problems of organismal maladjustment. Such medicine today is not interested in the use of Procrustian beds into which "insane" people may be fitted and there treated in cubicles set aside "for psychiatry only." It is operative in home and business relationships, in schools, church parishes, general hospitals, CCC camps, the courts, etc.; it finds few areas of thought and action entirely alien to its interests, and seeks an ever-increasing rapport with those who speak with authority from the outposts of science. Mental medicine today pushes forward in the direction of sane thinking and behavior, seldom so dramatically as in the "shock treatments" of the psychoses, but continually toward goals that gradually become clearer.

* Rogers Memorial Lecture, presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

Education

Medical schools are gradually developing their psychiatric curricula. Sixty-eight schools now give psychiatric instruction of reasonably high standard; in some of these the students are trained from the freshmen year up to accept psychiatric insight as a necessary adjunct in the practice of clinical medicine. Six-month internships in state hospitals, preceding or quite directly following those in general hospitals, have been for some years a common practice in Illinois, with excellent results.

Psychiatrists with a proper educational background are now being certified by a national examining board as qualified to practice in this field of medicine—an official evidence of competency that is becoming increasingly frequent in the various specialties.

Out beyond the limits of the profession, educational work progresses in colleges, normal schools and theological seminaries. During the past seven years the Elgin State Hospital has participated, along with a number of others, in a national project for the instruction of theological "student-interns" in the field of abnormal behavior—an increasingly active movement for training, under adequate supervision, groups of young men during the summertime in a better understanding of the sources of human "sinfulness."

Education of the laity lies principally in the field of mental hygiene, aside from an increasing effort on the part of state hospital staffs to give informative, community lectures and to conduct intramural ward walks and clinics for interested groups of nurses and college students. For example; at Elgin,

during the first six months of the year, thirty-two such groups have visited the hospital with their instructors—over 1,000 individuals in all.

Institutional Psychiatry

Sanitarium care gradually improves; in spots it is excellent, and in others not so good. Of late there has been some movement toward the endowed, nonprofit sanitarium—a desirable, though not intrinsically necessary, departure. Such an institution in the East has been doing notable work for some years now, and another in the Middle West has recently followed suit. There may be others with which I am not familiar.

About 500,000 mental patients are receiving hospital care today, the vast majority of whom are in state hospitals where administrative psychiatry proceeds in some regions at a painfully slow pace. The state hospital situation continues to exist, quite generally, within the framework of politics, and superintendents are still being appointed who have not had previous psychiatric experience; hence, definitely pointed, long-term policies pertaining to building programs, planned management, extramural supervision of patients, affiliation with medical schools, research, etc., are rare. In certain areas superintendents engage in a low per capita cost competition that discourages medical progress.

I seriously doubt if the sum total of papers read by mental hospital staff members before county and state medical societies is increasing and question just where the blame, if blame there be, may lie. The subject matter, *as offered*, too often fails to appeal to men who feel that their work concerns only "physical illness," men whose medical orientation, perhaps through no fault of theirs, is not consciously broad enough to envisage the organism as a whole. I say "not consciously broad enough" advisedly, because no physician can practice medicine for a day without considering at least some of his patients as whole individuals in the throes of adaptational struggles.

Although much of the more stimulating work in mental medicine is still done outside of state institutions—aside perhaps from teaching institutes — hospitalized patients constitute a mass of human material and data, ready at hand for the use not only of psychiatrists, psychologists, criminologists and sociologists, but of those especially interested in problems pertaining to surgery, internal medicine, gynecology, endocrinology, etc., etc. The word "investigation" used to cause superintendents and medical staffs to shiver; nowadays its connotations have become increasingly pleasant. In good state hospitals men of science are always welcome to carry on their studies, provided, of course, that nothing is done to traumatize the patient physically or emotionally.

Military psychiatry, in times of peace, is quite largely confined to institutional work. In the event of war, it must expand rapidly enough to deal with the many problems involving newly enlisted men in camps and in action, building on the foundation of experience gained in the World War. Unfortunately and inevitably this expansion must occur at the expense of civil psychiatric practice of all kinds, because of lack of funds, and loss of public interest and proper personnel.

Research

The report of the National Committee for Mental Hygiene for 1939 states that only twenty out of 273 public institutions can be designated as research centers, because of the character and quality of their investigatory work, the caliber of their personnel and the resources at their disposal for scientific studies; and, further, that some 150 out of 1,700 staff physicians show a marked interest in and an ability for investigative work. A pitifully small percentage! More than half of the few millions of dollars annually expended for psychiatric research in the United States is derived from foundations and individual and private agencies. This is a poor showing when viewed in the shadow of an expenditure of half a million dollars daily for hospitalized mental patients.

Fortunately, the practical results of investigation are often unrelated to the number of dollars invested — witness the recent "shock therapies" of Sakel and Meduna, so quietly developed upon a clinical basis. Inevitably, however, these treatments in turn

are stimulating an immense amount of research effort in an attempt to explain and evaluate the improvements obtained. And the theories thus evolved are leading to the development of various modifications and substitutes for these bewildering therapies.

Research along almost any line, in all sorts of laboratories, may have its repercussions upon psychiatric practice. Thus when an obscure chemical, long stored upon the shelves of many stock-rooms, was found to be a vitamin B complex and good treatment for "black-tongue" in dogs, and for pellagra in humans, articles soon appeared upon *sub*-pellagrous states of mental confusion which yield to the administration of nicotinic acid.

As far back as 1927, Berger found that the brain displays electric potentials that can be recorded in much the same manner as electrocardiographic waves. Nowadays the electroencephalographic study of brain activity is one of the most interesting lines of research in mental medicine, as well as in physiological laboratories. Today at Elgin, we are checking, with this new implement, the effect on the brain of shock therapy and various other agents affecting its activities.

Research proceeds at times by leaps and bounds and again by laborious attempts to determine the reasons for results obtained. Commonly speaking, new therapy nowadays follows research, although it often impatiently proceeds upon its way regardless of the fact that the preliminary investigative work has not yet been completed.

Treatment

I cannot enter here into a detailed consideration of treatment. Most noteworthy in this connection is the fact that psychiatrists today commonly speak of the *organism-as-a-whole* when considering diagnosis, prognosis and treatment. The general practitioner readily recognizes classical examples of the tall, "wet-string" person with clammy hands and inverted thinking, as well as the stocky, plethoric, "out-going" opposite, and knows that the former may eventually suffer from dementia praecox as well as gastrointestinal disturbances, while the latter may develop states of excitement or depression, as well as hypertension.

Dunbar and her associates,[1] for the past four years have been investigating the mental difficulties encountered in certain classifications of general hospital patients, at the Presbyterian Hospital in New York City. Their studies of those suffering from diabetes, heart disease, or fracture, reveal definite psychopathologic conditions in connection with the organic illness in 38.7 per cent, —and over a half of the total admissions could not be studied because of the advanced stage of illness. They are satisfied that if they could get to such patients soon enough, over 79 per cent would exhibit definite evidence of psychic difficulties relatable to, or complicating, the disease or accident. General hospital staff physicians exposed to insights of this kind, are almost certain to be converted to the idea that they are dealing with the whole patient and not merely with a diseased or injured part.

And conversely, no mental patient can be adequately treated without the most thorough-going physical examination. For example; a short time ago, at Elgin, a much disturbed colored woman was found to have a large fibroid of the pelvis and a high nonprotein nitrogen. In fact, the nonprotein nitrogen was so high that the advisability of operation was questioned. After removal of the fibroid she recovered mentally, as well as physically. As Golla[2] has remarked: "Science, as MacMurray reminds us, is description but not knowledge, for knowledge is of the total presentation and the total is always more than the sum of the parts;" and, again, "We are, indeed, reluctantly re-learning a fact that was very apparent to our forefathers—the truism that we think and act with the whole organism."

Mental medicine unquestionably secures increasing benefits from psychoanalytic insights, and yet few psychotic individuals can actually be cured by psychoanalysis, which must principally deal with the neuroses, so far as treatment is concerned. Today many of the younger psychiatrists assume that they must also qualify as psychoanalysts. Whether this means a drift away from sound medical thinking remains to be seen.

What Myerson[3] has recently called the "total push" method is a common sense state-

ment of the fact that we must make use of every proper surgical and medical treatment, plus psychotherapy, and whatever environmental conditions may be available for the purpose of healing. This healthful conclusion very properly reminds the psychiatrist that he is fundamentally a physician with a specialized orientation.

Mental Hygiene

The mental hygiene campaign continues with perhaps less enthusiasm, but more hard sense, than formerly. It is useless to think of materially influencing the mass behavior of human beings within two or three decades. The most notable drive in a single direction concerns child guidance. Unfortunately, parents and teachers are not always wise, because they, themselves, have not been brought up properly. Of the 100,000 persons to be admitted to mental hospitals this year in the United States, approximately a third will be under 35 years of age and the majority of them will suffer from what we please to call dementia praecox. In addition to these psychotic persons, twice as many nonhospitalized neurotic ones will probably become increasingly less able to deal effectively with life. A great many of these young people might have done much better if they had been properly reared. As stated in the June, 1939, annual news letter of the National Committee for Mental Hygiene, "Public, growing interest and faith in the therapeutic, preventive, educational and social value of organized mental health endeavor, is strikingly exemplified in this far-flung support (by public agencies, private foundations and state funds) of the child guidance movement, which has furnished impetus and set the pattern for the increasing development of community mental health services for the adult and adolescent, as well as for the child."

Personnel guidance is an example of a desirable psychiatric function which is slowly structuralizing *in situ,* as an off-shoot of mental medicine. V. V. Anderson[4] observed in a large industry which he surveyed, that job failures among young people coming fresh from public schools were the result of poor personality reactions, and amounted to *thirteen* times more than the job failures of the more seasoned personnel of this concern as a whole. No complaints were made by the foremen concerning the employes' poor intelligence, lack of education, bad health, insufficient skill, etc.; unfortunate individual make-up alone seemed responsible for their failure to make good.

Criminology

Judges of the criminal courts increasingly refer delinquents for mental examination. The municipal courts of Chicago maintain a psychopathic laboratory for this purpose. In the Cook county jail, for some years, there has been an observation ward, under psychiatric direction. Case work in juvenile courts has long since become an established practice.

In 1933 Illinois established depots for the examination of felons (as sentenced) by psychiatrists, psychologists, and sociologists, in an effort to estimate their physical condition, intelligence, psychosis (if any), personal make-up, and social reaction-patterns. Final consideration of the assembled results, by the chief psychiatrist, determines prisoner classification and treatment within the penal system. This procedure in addition to psychiatric work within the various prisons themselves, constitutes a notable extension of mental medicine in the field of penology. The segregation of certain feeble-minded delinquents to prevent their apparently inevitable commitment of major crimes, seems to be another real advance in criminologic practice.

Of necessity much has been intentionally omitted from this sketch of mental medicine *en route* to many objectives. Much territory remains to be occupied, many gains are still to be consolidated. The accompanying cut attempts to visualize in two dimensions the present day development of mental medicine in its various modalities. From its origin in general medicine (projected as a circle in the diagram) it is extending in many directions far beyond the generally accepted boundaries of medical practice. It is a procedure, dynamic not static, an orientation of thought, an increasingly effective attempt to envisage, evaluate and aid human beings in their

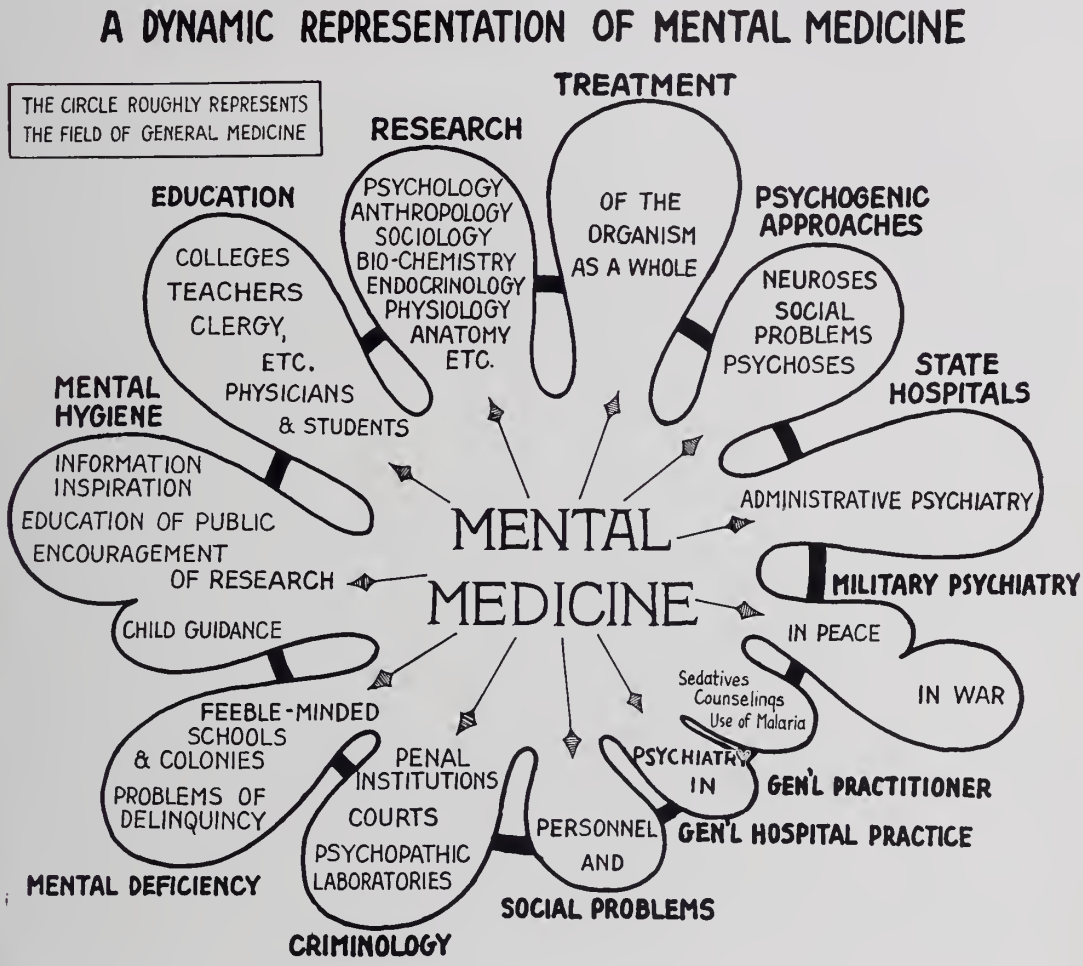

Fig. 1. Visualization in two dimensions of present day developments of mental medicine in its various modalities.

adaptational struggle with poor heredity, faulty upbringing, unfortunate family and group inter-relationships, poverty, disease, and the many other evils with which they have to contend.

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Sulfapyridine (Dagenan) in the Treatment of Pneumonia

A Preliminary Report of Its Use in 90 Cases*

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Synopsis of Earlier Effort

Since the first report by Whitby[1] on the action of sulfapyridine on the pneumococcus, considerable clinical investigation has been carried on not only in regard to the effect of the drug on the pneumococcus but also on many other organisms.

Whitby[2] in discussing the action of sulfapyridine states that it is effective against the pneumococcus, meningococcus, hemolytic streptococcus, B. coli and Staphylococcus aureus and that there has been a favorable report in regard to experimental Pasturella pestis and in a case of H. influenzae meningitis. In addition a remission in a case of pemphigus was reported, and it was found to be effective in gonorrhea. It was found to be ineffective against H. pertussis. In regard to the mode of action of the drug he states that it exerts a bacteriostatic or perhaps a bactericidal action on the invading organism which allows the body to eliminate the infection. It also exhibits a definite detoxifying or immunizing action in that it neutralizes toxins and stimulates phagocytic activity. In experimental animals treated prophylactically with sulfapyridine, multiplication of pneumococci in the peritoneal cavity ceases after seven hours and capsular degeneration occurs. Whether this capsular degeneration is associated with loss of type specificity and virulence was not confirmed by these original experiments.

Long[3] was unable to see these specific changes in the capsule of the pneumococcus when experimental infections were treated with sulfapyridine.

Fleming[4] has shown that when sulfapyridine is mixed with pneumococci and deleukocyted blood in vitro, there is a definite bacteriostatic effect as evidenced by the formation of only minute colonies even in dilutions as high as 1 in 128,000. In addition, if sulfapyridine is mixed with pneumococci and blood containing its full complement of leukocytes there is a complete inhibition of growth in dilutions as high as 1 in 64,000, thus showing a definite bactericidal effect.

Case Reports

WE USED sulfapyridine** in ninety cases of pneumonia in order to determine the toxic manifestations of the drug and its effectiveness against the pneumococcus. The four cases cited here illustrate the main types of response observed. The first, (fig. 1), shows a rapid decline in the fever and subsidence of toxicity; in the second, (fig. 2), there was a secondary rise in fever due to a recurrence of the pneumonia after the drug had been prematurely discontinued; in the third, (fig. 3), fever continued for a period comparable to a normal course for pneumonia but with complete, uncomplicated recovery; the fourth, (fig. 4), shows the occurrence of a secondary fever, probably the result of an inadequate dose, followed by a marked response when an increased amount of sulfapyridine was given.

Case 1.—G. P., a white male aged 26 years, entered the hospital on the fourth day of the disease complaining of weakness, shortness of breath, hemoptysis, chills and fever. The temperature was 104.6 F., the pulse rate 136 per minute and the respirations 30 per minute.

Physical examination revealed a well developed white male who was dyspneic and expectorating a bloody sputum. A diagnosis of left upper lobar pneumonia was made and was verified by x-ray examination. The sputum showed a type 1 pneumococcus. The patient was given 2 grams of sulfapyridine as an initial dose and then 1 gram every four hours until a total of 25 grams had been given. He became much less toxic and the temperature subsided to normal after 8 grams of the drug had been given. His course in the hospital was uneventful and recovery was uncomplicated. The blood concentration of the sulfapyridine varied between 1.0 and 2.3 mg. per cent. The toxic symptoms referable to the drug were nausea, vomiting and anorexia on the fifth and sixth days of the disease. The blood count on entrance showed 17,700 leukocytes per cmm. and 4,280,000 red blood cells per cmm. There was no significant change at any time during the course of the disease.

This case illustrates a prompt response to sulfapyridine. The rapid decline in temperature and the termination of the toxemia is comparable only with the crisis in the usual course of the disease.

Case 2.—F. M., a white female aged 41 years, entered the hospital on the third day of the disease complaining of pain in the lower left side of the chest exaggerated by inspiration, dyspnea and cough with expectoration. The temperature was 103.6 F., the pulse 120 per minute and the respirations 28 per minute.

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* From the medical clinic of the Milwaukee County Hospital and the department of medicine, Marquette University.

** The drug used in this series of cases was furnished by Merck and Company, Rahway, N. J.

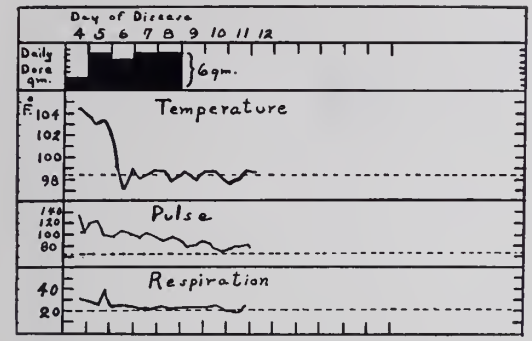

Fig. 1. Shows the rapid drop in temperature in case 1.

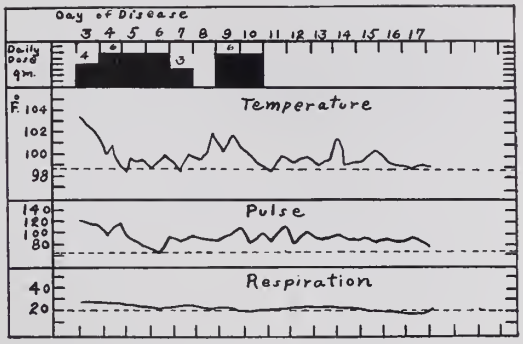

Fig. 2. Shows the secondary pyrexia in case 2.

Physical examination revealed a well developed and well nourished white female who appeared acutely ill. The respirations were rapid, shallow and associated with an expiratory grunt. On examination of the left chest a diagnosis of a left lower lobar pneumonia was made, and was confirmed by x-ray examination. The sputum showed a type 1 pneumococcus. The patient was given 2 grams of sulfapyridine as an initial dose and 1 gram every four hours until 25 grams had been given. The temperature fell to normal after 10 grams had been administered. On the eighth day of the disease, after the drug had been discontinued, the temperature again rose to 102 F. and the patient appeared somewhat toxic. Sulfapyridine was again given in a dose of 1 gram every four hours until another 12 grams had been administered. After this the temperature fell toward normal and the patient made an uneventful recovery. The blood concentration of the sulfapyridine varied between 8.9 and 14.4 mg. per cent. No toxic symptoms referable to the drug were noted. The red blood cell count fell from 5,400,000 per cmm. on entrance to 3,700,000 by the seventh day of the disease. The leukocytes varied between 8,700 and 11,400 per cmm.

This case is presented because it shows a secondary pyrexia due probably to a relapse in the disease, and its subsequent control with the re-administration of sulfapyridine. In all cases treated with the drug a secondary fever due to a recurrence of the disease should be watched for and the therapy should be resumed as soon as it is observed. Treatment should not be discontinued the moment a favorable response is obtained because the infection may still be potentially active.

Case 3.—J. H., a colored male aged 43 years, entered the hospital on the fourth day of the disease, complaining of pain in the left anterior portion of the chest and moderate cough and expectoration.

Physical examination revealed a well developed and well nourished colored male who appeared acutely ill. The respirations were shallow and rapid and there was an expiratory grunt. A diagnosis of a left upper lobar pneumonia was made and confirmed by x-ray examination. The sputum showed a type 7 pneumococcus. The patient was given sulfapyridine in an initial dose of 2 grams and then 1 gram every four hours thereafter until a total of 56 grams had been given. The disease ran a protracted course, the temperature falling to normal on the eleventh day (after seven days of sulfapyridine therapy). During the course of the pneumonia the patient appeared very ill but was at no time in a critical condition. His respirations became labored and he seemed to be weak and somewhat lethargic. On the ninth day, the x-ray examination showed, as before, an involvement of the left lower lobe. The blood concentration of the sulfapyridine rose as high as 3.7 mg. per cent. Nausea and vomiting occurred on the fourth and fifth days but disappeared after that although the drug was continued. Cyanosis was also noted but was not marked. The red blood count fell from 4,500,000 per cmm. on entrance to 3,400,000 per cmm. by the eleventh day of the disease. The leukocyte count rose from 4,500 per cmm. on entrance to 22,400 per cmm. on the thirteenth day of the disease.

This case exemplifies an unusual response of pneumonia to sulfapyridine. There appeared to be a delay or even an absence of the effect of the drug. However, clinically the patient progressed satisfactorily and at no time was it felt that his life was threatened by the disease. Whether the course of the pneumonia was actually modified as it appeared to be or whether it was a normal one for pneumonia cannot be accurately judged. The fact that the leukocyte count rose from 4,500 to 22,400 per cmm. shows that the dreaded leukopenia may not always occur.

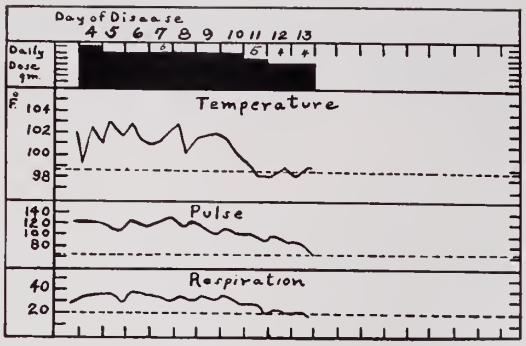

Fig. 3. Shows the gradual decline in temperature in case 3.

Case 4.—R. Q., a white female aged 26 years, developed a sudden pain in the right lower chest posteriorly, followed by a chill and fever on the second postpartum day. The temperature was 104 F., the pulse 132 per minute and the respirations 32 per minute.

Physical examination revealed a well developed and well nourished white female who was acutely ill. The respirations were rapid and shallow and there was a slight cyanotic tinge to the lips. A diagnosis of right lower lobar pneumonia was made and verified by an x-ray examination. The sputum showed a type 1 pneumococcus. The patient was given an initial dose of 2 grams of sulfapyridine followed by 1 gram three times a day. On the fifth day of the disease the temperature rose and the dose was increased to 1 gram of the drug every four hours. After two days the clinical improvement warranted discontinuation of sulfapyridine and the patient made an uneventful recovery.

This case emphasizes the necessity of giving adequate amounts of the drug. It is true that a standard dosage scheme is still lacking, but because of the irregularity with which the drug is absorbed, fairly large doses are required. They may be reduced if unfavorable reactions occur.

Discussion

Our experience with sulfapyridine in the treatment of pneumonia corresponds in a general way to that reported by numerous investigators in England[5,6,7,2,8] and America.[9,10,11,12,13] Any therapeutic agent as effective as sulfapyridine appears to be in the treatment of pneumonia would naturally be received with great enthusiasm, but, despite the excellent results that we have obtained, we wish to emphasize the importance of caution in recommending the drug too enthusiastically at this early date. While we have been more than pleased with the favorable outcome of our patients with pneumonia after the administration of sulfapyridine, we believe the warnings such as that given by Marshall[14] must not be cast aside too lightly. This is particularly true because the action of the drug is not entirely understood, and sufficient time has not yet elapsed to be certain that no untoward after-effects will develop.

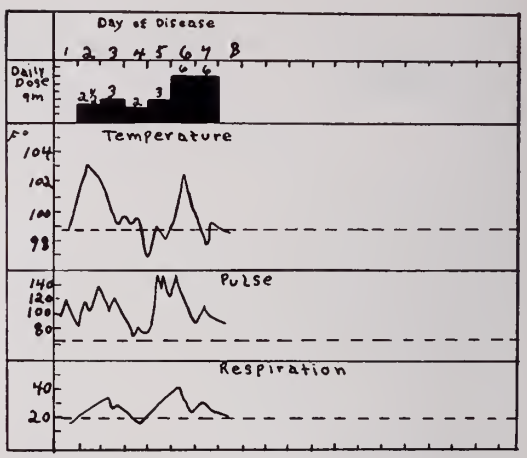

Fig. 4. Shows evidence of relapse due to inadequate dosage in case 4.

Our ninety cases were selected with the idea of determining the effect of sulfapyridine on patients with lobar pneumonia due to the pneumococcus. Therefore, patients with other known complications such as definite heart disease, renal insufficiency or tuberculosis were not chosen. We believe that this is the only fair way to select cases for experiment, for, after all, it is the effect of sulfapyridine on pneumonia that we are trying to determine rather than its action in patients with pneumonia combined with other active organic lesions which in themselves would have an unfavorable influence on the course of the disease.

The diagnosis of pneumonia was made certain in all ninety cases by clinical and x-ray examination of the chest. Analysis of the sputum for the type of pneumococcus was made in every case, and blood cultures were taken in most instances. An important factor in the outcome appears to be the com-

mencement of treatment within three days of the onset of pneumonia. Patients treated early responded more promptly and recovered more quickly and completely than those in whom the drug was started after the third day of the disease. As far as we have been able to determine, the type of pneumonia does not make much difference in the outcome. This statement, however, may have to be modified as more observations are accumulated. Experimental work has shown that the action of sulfapyridine is enhanced by the coincident use of serum, but, since the purpose of this study was to determine the effectiveness of sulfapyridine against pneumococcic infection, serum was not used.

The dose of the drug used was that recommended by the original investigators,[6] an initial dose of 2 grams followed by 1 gram every three to four hours until about 25 grams had been given. A normal temperature for forty-eight hours and an improvement in clinical condition were the criteria for determining when the drug should be stopped. Some patients responded so well that the drug was discontinued after 12 to 15 grams had been given. It appears unwise to do this because in such cases a secondary rise in fever and recurrence of symptoms of pneumonia followed within a few days. In some cases we gave larger doses during the first twenty-four hours than have been recommended by other observers. For example, in one case, 4 grams were given at once followed by 1 gram every two hours until 24 grams had been administered. The response was very satisfactory.

Recently Brown, Thornton and Wilson[15] have used the soluble sodium salt both intravenously and intramuscularly in the treatment of pneumonia. They found that the intravenous method produced a very high concentration almost immediately, followed by a fall within 30 minutes to a level which may be considered an effective maximum concentration. When given intramuscularly the maximum concentration was attained in three to three and one-half hours, and, in one patient treated with intramuscular injections, the excretion of the drug was more prolonged than usual. In view of the possibility of delayed toxic reactions, this point must be kept in mind when using the drug by this route.

Sulfapyridine occurs in the blood stream in two forms, the free and the conjugated. The determination of the amount of free sulfapyridine in the blood was made daily in most of our cases. From our observations to date it appears to make little difference whether the sulfapyridine is present in concentrations of 3 mg. per cent or 12 mg. per cent. Some of our patients with lower concentrations progressed more favorably than those with higher concentrations. Our experience corresponds with the observations of others that about 4 mg. per cent seems to be the optimum concentration. We observed closely the period of time required for the body to eliminate sulfapyridine from the blood stream. In one case, which may be taken to exemplify the whole group in this regard, the drug was stopped at 10 a. m. on Sunday after 30 grams had been administered. The sulfapyridine in the blood stream was 8.6 mg. per cent. On Monday morning at 10 a. m. the blood was studied and was found to be free of the drug.

We did not observe post-pneumonia phlebitis, lung abscess or pericarditis. Empyema developed in three cases but cleared up readily with the usual treatment.

The toxic reactions resulting from sulfapyridine have been carefully noted in every case. No alarming toxic manifestations developed. Leukopenia occurred in two cases but caused no difficulty. In some instances a leukopenia at the onset of pneumonia was followed by a pronounced leukocytosis. Anemia, purpura and dermatitis were not observed. However, we advise that the patients be followed closely with blood counts at least every other day because several cases of acute hemolytic anemia and agranulocytosis and one case in which there was a leukemoid reaction[16] have been reported in the literature. The most bothersome reaction we encountered was nausea and vomiting which were so severe in about 8 per cent of our cases that the drug had to be discontinued. When treatment was stopped these symptoms subsided. In the majority of troublesome cases the following methods were tried with considerable success:

(1) Crushing the tablets and suspending in milk or fruit juice.

(2) The administration of unsweetened carbonated water (seltzer water) simultaneously with the tablets.

(3) Readministration of the tablets as above half an hour after emesis. (At times the patient was able to retain the tablets after this second attempt.)

(4) The administration of sodium chloride solution intravenously (300 cc. of a 3 per cent solution) or dextrose intravenously (500 cc. of a 10 per cent solution).

In most cases the nausea and vomiting disappeared after a day or two even though the administration of the drug was not interrupted. Cyanosis was observed in about 40 per cent of our patients, but in no case was it necessary to discontinue the drug because of this. In some instances this condition is probably due to the pneumonia rather than to the effect of the drug; in others the formation of sulfhemoglobin accounts for it. If cyanosis is due to sulfhemoglobinemia the administration of 0.1 to 0.2 cc. of 1 per cent methylene blue per kilogram of body weight will serve to clear away the blueness, but if it is the result of the lung disease methylene blue will not be effective. Drowsiness and lethargy were noted in 10 per cent of the cases, but no disturbances of the central nervous system, such as loss of memory, irrationality and depersonalization, were observed. Headaches occurred in over half of the cases and we used acetylsalicylic acid and soda to relieve them.

There were four deaths in our series of ninety cases. This corresponds to other reports in the literature and indicates a considerable decrease in the mortality rate over other forms of treatment. Evans and Gaisford[6] report a mortality of 8 per cent in 100 patients with pneumonia treated with sulfapyridine as compared with a mortality of 27 per cent in an equal number of controls. Flippin and his associates[17] report a series of 100 cases with only four deaths. Mortality figures alone do not convey the excellent results obtained with sulfapyridine. It was a frequent occurrence to see patients who were acutely ill with pneumonia one day practically well the next. This dramatic response seen in so many cases may be taken as a measuring stick of the drug's efficacy in the treatment of pneumonia.

Conclusions

Although we have been as enthusiastic as others over the results of our experience with sulfapyridine in the treatment of pneumonia, we believe that another year's experience will be necessary before a final appraisal can be made. It may be that we have passed through a winter in which there have been a large number of mild pneumonias and that other types of treatment would have been satisfactory. If the next year's experience continues to be favorable we can feel certain of the reliability and effectiveness of sulfapyridine in pneumonia.

There are four definite advantages which we have observed in the use of sulfapyridine:

(1) The drug is effective in most cases of pneumonia.

(2) The treatment is simple. This is a sound recommendation especially for general practitioners who are not located near the larger hospital centers.

(3) The cheapness of the drug is an important factor which must not be overlooked.

(4) The drug may be used in any pneumococcic pneumonia regardless of the type. This eliminates expense to the patient, trouble on the part of the physician and renders the drug practical for treatment in the home.

Certain disadvantages must also be kept in mind:

(1) Although the immediate effects of sulfapyridine have been favorable, unforeseen remote consequences may develop. This is particularly brought to mind by the recent experimental work of Gross, Cooper and Lewis,[18, 19] and Antopol and Robinson.[20] These investigators found that urinary calculi may develop in rats and dogs following the administration of sulfapyridine. Although this has not occurred clinically to our knowledge, the possibility must not be overlooked. Southworth and Cooke[21] reported three cases in which there was hema-

turia. In two of them there was associated renal and ureteral pain, and renal insufficiency and nitrogen retention developed. In all three cases the symptoms cleared up promptly when sulfapyridine was stopped and fluids were forced. Other sequelae such as effects on the bone marrow, nervous system and other organs must also be considered.

(2) Immediate toxic reactions such as dermatitis exfoliativa, granulocytopenia and acute anemias become serious complications at times.

(3) It must not be forgotten that, if this drug is as widely used as now appears probable, pneumococcic typing and serum therapy may be discontinued by a large number of institutions. This might act as a stumbling block in the progress of our knowledge of pneumonia which was advanced very rapidly by the excellent work on pneumococcus typing and the use of specific serum therapy.

Sulfapyridine may share the fate of other specific forms of treatment that have been introduced. Frequently there is a stage characterized by widespread use and enthusiasm which leads to injudicious application of the remedy to various unrelated conditions; this is followed by a period of condemnation of a fairly satisfactory form of treatment.

The combination of serum and sulfapyridine is believed by many to provide the most effective method of treatment and leads to less frequent complications. It is claimed that less sulfapyridine is necessary when specific serum is used with it. While our observations are too limited for a complete appraisal of the value of sulfapyridine therapy in the treatment of pneumonia the results obtained so far seem to indicate that this is a safe and adequate therapeutic measure in the majority of cases. It appears to us that it will take a number of years before the final decision as to the relative merits of sulfapyridine alone, serum alone or the combination of the two can be made.

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Amblyopia

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A GREAT deal has been written on the subject of amblyopia, but, to most medical men, it is still a rather vague eye condition about which nothing much can be done. Very little that is new can be written about this condition but, from time to time, facts already known may be given emphasis and by reiteration help the general practitioner to a better understanding of his opportunities and responsibilities in regard to amblyopic patients.

It must be kept in mind that amblyopia is an acquired condition in many, if not most, cases, and, with the proper management, much can be done to prevent and also to correct it.

Amblyopia, within the scope of this paper, is a functional condition characterized by subnormal vision in one or both eyes, for which no sufficient pathologic basis can be found and in which no corrective lenses can be applied to give normal vision,—the so-called "amblyopia ex anopsia" or partial blindness from non-use of the eyes.

Notes From the Literature

Fuchs[1] says: "Amblyopia (ex anopsia) from non-use occurs when there has been present from earliest childhood an obstacle to vision, which makes the formation of sharp images upon the retina impossible . . . A similar amblyopia from disuse occurs in eyes affected with high uncorrected refractive errors (especially high astigmatism) and particularly in the more ametropic eye in anisometropia. Amblyopia also develops in an eye which has squinted since childhood, because in this case the perception of the retinal images in this eye is suppressed, and the eye is thus purposely excluded from participation in the act of vision. In all these cases, the retina, owing to lack of exercise, fails to attain to that delicacy of function which belongs to normal eyes, or the functional capacity which has been already acquired is lost; but absolute blindness never occurs."

Fuchs' classification of disturbances of vision without apparent lesion is given below:

"I. Disturbances of sight seated in the eye itself.
  (a) Congenital amblyopia
  (b) Amblyopia ex anopsia
"II. Disturbances of sight of central origin."

(This paper is not concerned with this last group except insofar as many cases now considered as belonging to the first group may belong to the second group, as they may be of central origin.)

According to Peter[2], three groups of acquired amblyopia are:

I. "Amblyopia in cases of monolateral eso — or exotropia.
II. "Amblyopia in adolescence and in adult life, with a history of squint in early childhood.
III. "The type which is observed in adults without a history or other evidence of squint in childhood."

Abraham[3] bases his classification on the character of the suppression. He states: "This is made possible by the division of acquired amblyopia into two main types: (a) passive suppression amblyopia, which is due primarily to lack of opportunity of the visual apparatus to function fully because of lack of correction, or late correction, of the error of refraction, and (b) active suppression amblyopia, in which binocular fixation results in discomfort or confusion or in which it is undesirable or impossible for other reasons, and therefore a special effort to produce poor vision is made. The refractive error may have nothing to do with the latter form, while strabismus seems definitely related." He concludes that the amblyopia is due to failure to use the potential visual powers fully and that response to proper treatment is usually favorable at any age.

Goodman[4] has done some interesting experimental work on rabbits. He concludes also that potentially normal vision exists and that in rabbits, even though the optic system does not function up to the sixth month, the reflex centers and retina will develop normally. Most investigators, however, are agreed that suppression of the image in an eye which is in some way different from its fellow leads to a non-development in the macular region or in the visual pathways, which, if uncorrected long enough, will become permanent.

Rea[5] states, "An amblyopic eye is . . . an acquired condition, . . . The sight of an amblyopic eye cannot be restored after seven years of age."

Peter[2] stresses the need for orthoptic treatment in the first five years of life and states that after seven years of age not much improvement can be expected. According to Peter, there are several phases which are found in each of the amblyopic groups which he mentions, viz:

(1) A central scotoma about 3 degrees in diameter; a moderate contraction of the peripheral fields for form and color; an enlargement of the blind spot.

(2) A rather high hyperopic error with anisometropia as an outstanding feature.

(3) A subnormal fusion faculty with varying degrees of depth perception.

(4) An hereditary strain of squint as a preceding factor or the appearance of monocular esotropia in the offspring.

In discussing congenital amblyopia, De Schweinitz[6] says: "The faulty vision has existed since birth, and often high grades of refractive error, especially hyperopia and astigmatism, are present, and clear images have never been focused upon the retina. Correction of the optical error usually fails to improve, materially, the vision; the retinal images continue to be defective. In very young patients an eye of this character may occasionally be trained

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to more nearly perfect vision after a proper correction of the refractive error, and this attempt should always be made."

The Author's Study

In order to gather some data concerning these cases, I have sorted out the records of 180 patients with amblyopia and listed them according to certain headings.

I have grouped each one according to family history of amblyopia, strabismus (and whether it was helped by glasses), the type of the refractive error, and the vision —with and without glasses. The 180 patients were, at the time of the first examination, between the ages of 3 and 67 years and constituted about 1 per cent of our refractions.

I found that the right eye was involved in 36 per cent, the left eye in 55 per cent and both eyes in 9 per cent. Only 6 per cent had a family history of amblyopia and only 30 per cent of the total had squint. Three per cent gave a history of some childhood disease causing the squint, the most frequent (four out of five) being whooping cough. It is very probable that if squint developed in every case instead of in less than a third, the condition would be recognized and treated earlier. Hyperopia and hyperopic astigmatism were present in 83.4 per cent. Myopia and myopic astigmatism were found in only 6.6 per cent. Eighteen, or exactly 10 per cent, were found to have a mixed astigmatism. All refractions were done under a mydriatic which dilated the pupils and paralyzed the accommodation. A careful examination was made of the fundus and media of each eye to rule out pathologic conditions.

Most of the patients, except those who were brought in on account of a strabismus, complained of poor vision or headaches, and sometimes eyestrain involving the amblyopic eye. Most frequently it was found that eyestrain headaches were due to overuse of the good eye. It is not uncommon to find an adult with an amblyopic eye who has never discovered his subnormal vision.

All of the patients in the series were fitted with glasses. In thirty-three, each with a relatively low refractive error, a comparison between the corrections given showed a difference of one-half diopter or less between the two eyes. In other words, in nearly 18 per cent, there did not appear to be enough difference between the correction given the two eyes to explain the amblyopia. More than half of this group of patients, or eighteen out of thirty-three, had a marked strabismus which probably accounted for the amblyopia. In the entire group, only about 30 per cent had strabismus, while in the thirty-three patients just mentioned, more than 50 per cent had some type of squint. This would lead to the assumption that anisometropia, mostly hyperopic, accounts for the largest group of amblyopia and also that, where the refractive error does not account for the amblyopia, the strabismus, when present, probably does.

High refractive errors, especially hyperopia and astigmatism, have long been described in amblyopia. The exceptions to this rule are what make the study of the condition interesting. Like most men in eye work, my colleagues and I have not found time to devote to strictly orthoptic training of patients with early amblyopia. Hitz[7] has solved the problem here in Milwaukee with the Orthoptic Clinic. Because of inability properly to follow up amblyopic patients, it is not possible to give a report of a large number of cures. The progress noted in occasional cases, however, is very encouraging. Seven patients have had amblyopic vision brought to normal. These seven were children ranging in age from 3 to 11 years.

One individual, aged 38 years, who had lost his left eye soon after birth, was found to be amblyopic although he had worn fairly accurate glasses since early childhood. The correction given contained a four and one-half diopter cylinder and improved his vision only one-tenth above that with the glasses he had been wearing. Right vision with correction was 20/50. He did not develop normal vision as did the patient in the interesting case reported by A. W. Green,[8] who had complete return of sight in an amblyopic eye following treatment over a period of ten years and loss of vision in the other (the left) eye. Green concludes: "This case affords an interesting illustration of the importance of persisting, even over

long periods, in the occlusion of amblyopic eyes, particularly at an earlier age, when there is much more possibility of the return of sight." His patient was 35 years old at the time vision failed in her left eye.

The difficulties involved in trying to get parents and others who are interested in child training to bring the child in early, are well illustrated by an examination of the age grouping of the 180 patients in this series. While sixty-six of them were 12 years of age or less, the number brought in between the ages of 3 and 5 years, when the most good can be accomplished, was only thirteen. In the fifty-three patients with strabismus, glasses caused improvement in eighteen, correction of the condition in eleven and no improvement in twenty-four. Four of these patients were operated on for cosmetic reasons. Twenty-nine with strabismus were helped sufficiently by glasses to get very good cosmetic results without surgery.

In the treatment of amblyopia, as in the treatment of other conditions, every case is a problem by itself. The general physical condition of the patient must be kept in mind as well as the home environment. Parents vary in their desire or ability to cooperate. The patients object to the occlusion of the good eye for long periods of time and the average parent will not insist on it. My associates and I have only *insisted* on occlusions from two to four hours daily, believing that much, at least, would be done. Occlusion for longer periods gets better results and this is now advised by us.

In the fitting of glasses in strabismus, we have always made it a practice to prescribe the full correction, made under a mydriatic. We believe that subtracting even a half diopter from the full correction will unfavorably influence the result in many cases. Where the strabismus is not marked and complaint is made of blurring, it has sometimes been possible to reduce the full correction somewhat without increasing the angle of strabismus. In this series of 180 patients there were fifty-two with amblyopic eyes unimproved by glasses. Among these were five patients with bilateral amblyopia, and, in four of these five, there was improvement with glasses on one side only.

Conclusions

In a study of the records of 180 patients with amblyopia, a great preponderance of hyperopia and hyperopic astigmatism was noted. About 70 per cent never had strabismus. Because of the absence of strabismus many cases of amblyopia go unrecognized until adult life.

The only cases in which we found improvement, with normal vision in formerly amblyopic eyes, were all in children. We found that 71 per cent were improved by wearing the proper glasses. We know that, given this group in childhood and the institution of proper orthoptic training, many more good results could have been obtained.

The family doctor should advise a check-up of vision in every child to find these cases early. The old-fashioned notion that the child will outgrow cross-eyes should be dispelled and preschool examinations or at least kindergarten vision tests should be made. Illiterate charts are simple and should be used in all children. We find many pupils in the second grade who have not been taught the alphabet because methods for teaching word-reading are now in vogue. It would seem that there is a divergence of opinion as to the chances to help amblyopic patients materially after childhood. The attempt to help should be made in all cases, however, prescribing full correction made under a mydriatic, especially in squint cases.

The 180 patients whose records are here reviewed represent a fair cross-section of the type we are called on to examine. The chief problem is to explain to the patients or their parents just what they may expect in the way of improvement in the eye condition and how long it will be before improvement occurs. For this reason I have outlined a classification of this condition according to prognosis:

1. Bad prognosis
   Those with
   - (a) Squint not improved by correction
   - (b) Congenital amblyopia with or without anisometropia
   - (c) A high degree of ametropia and little, if any, anisometropia, especially when the amblyopia is in the eye with the least refractive error
   - (d) Amblyopia unrecognized until adult life, no matter what the cause.

2. Good prognosis
   Those with
   (a) Ages between 3 and 6 years
   (b) Vision in the amblyopic eye which is at least 20/50 with correction
   (c) Squint which correction improves or straightens.

When a large number of patients are grouped according to prognosis, there will be some who, no doubt, should be included among those with partial blindness of central origin.

Very few of the amblyopic patients seen by my associates and me are being brought to normal or near-normal vision. In those without squint, who make up more than two-thirds of our amblyopic patients, correct glasses should lead to great improvement over a period of years, but this is not true. They may not have true amblyopia from non-use. Instead their trouble may be due to defective visual pathways back of the eye or defective nerve centers in the brain.

While the cause of much amblyopia is still obscure and the chance of helping certain types questionable after childhood, the big majority of amblyopic patients are benefited by a careful eye test and glasses fitted under "drops." Where possible, orthoptic treatments should be given under the supervision of one trained in their application. When such treatments are not available, the physician making an early diagnosis should at least prescribe properly fitted glasses and the occlusion of the good eye over a period of time.

A classification based on prognosis may be of some help in predicting what improvement, if any, one may expect in any given case. While many patients are helped by carefully fitted glasses, very few are actually cured, unless treatment is started early in life—and then only a selected few. This sort of examination and treatment can be carried out only by the eye physician, or under his direction, with the full cooperation of the patient's parents, after a careful preschool-age eye test.

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Surgically Difficult Growths of the Female Pelvic Viscera*

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BECAUSE I have developed a major interest in pelvic anatomy in relation to gynecology, it has appeared to me a few minutes might be spent profitably in a survey of what I have been studying.

Anatomy

In a recent publication concerned with cystocele, it was demonstrated that, after removal of the intestines, peritoneum and subserous tissue, the firm fascia which lines the muscles of the pelvic floor is reflected upward as a collar over each of the three hollow viscera, namely, the bladder, the vagina and uterus, and the rectum. The relatively thin collar around the bladder is in apposition with the heavier vagino-uterine collar, the bladder pillars constituting a connecting bridge.

More recent observations in the operating room correlated with anatomical dissections have demonstrated the continuity of the investing fascial collars with the supporting structures at a higher level. Proceeding from above downward, the fascial invest-

* From the department of obstetrics and gynecology, Northwestern University Medical School and Passavant Memorial Hospital. Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

ment over the uterus first becomes distinct posteriorly slightly above the level of the uterine attachment of the uterosacral ligaments. Anteriorly, there is a remarkably broad attachment of the round ligaments down to the level of the broad ligament branch of the uterine vein; immediately below this point the fascial collar becomes dissectable.

Lateralward, the uterovaginal and vesical fascial coverings become continuous with the Mackenrodt ligament, which spreads out, tent-like, to become inserted, fan-shaped, into the fascia overlying the obturator muscle and the muscles of the pelvic diaphragm. With the peritoneum removed, one sees that Mackenrodt's ligament really begins, above, at the level of the obliquely coursing broad ligament branch of the uterine vein, and that there is a "core" consisting of this vein and the slightly more inferiorly placed uterine artery and accompanying vein, all enclosed in a vascular compartment; one notes also, posteriorly, that the uterosacral ligament is continuous laterally with and really is an integral part of Mackenrodt's ligament, as well as continuous with the uterovaginal fascial collar. Upward and downward extensions of the fascial sheath surrounding the vessels constitute firm investments accompanying the ascending and vaginal branches of the uterine artery and vein.

The course of the ureters is a topic of never-ending interest and concern, even to those most experienced. Noteworthy surgical landmarks therefore merit a few words: Upon entering the pelvis the ureter lies immediately medial to the attachment of the infundibulopelvic ligament at the pelvic brim. In peritonization, after removal of the uterus together with the ovaries, the ureter is therefore hazardously near, just beneath the peritoneum, and the peritonizing suture should never be deeply placed on the medial side without preliminary palpation of the ureter. Located 4 cm. from the uterus at the level of the internal os, the ureters are 1.5 cm. lateral to the lowermost cervix at the point of their greatest proximity to the uterus; in their downward course they lie beneath the tent-like, fan-shaped lateral extensions of Mackenrodt's ligaments, crossing under the uterine vessels, and situated approximately 8 cm. apart at the level where the pelvic surgeon usually places clamps on the vagina in performing a simple complete hysterectomy. Another landmark is afforded by the bladder pillars, the ureters being located just anterior to and 1 cm. lateral to the pillars. In the detail of radical hysterectomy for cancer it is helpful to know that the ureters enter the bladder obliquely convergent, ensheathed in extensions of the musculofascial covering of the bladder. Also worthy of emphasis here is the considerable fascial investment which extends along the ureter, thus creating a pathway for lymphatic drainage from the cellular tissues contained within Mackenrodt's ligament.

The anatomy of the bladder in relation to pelvic surgery intrigues me. The musculofascial investment is fortunately somewhat thicker on the inferior surface and is greatly strengthened by the contiguous, very much thicker musculofascial collar of the vagina and cervix. At complete hysterectomy, however, separation is made in the plane between the vesical and the cervicovaginal collars, where the vesical fascia is much attenuated, with the result that the integrity of the bladder wall is often endangered. This I have demonstrated repeatedly through the simple expedient of preoperative instillation of 20 cc. of 1:1,000 methylene blue solution into the empty bladder, as a safeguard: the blue solution shines through unduly denuded areas, warning of danger, and it spills in case of injury. In this connection, I am impelled to emphasize the frequency with which one invades the musculofascial envelope of the bladder in the routine of complete hysterectomy; also the hazard of tissue forceps injury and leakage from the bladder, doubtless accountable for some of the cases of fistula heretofore ascribed to the too deep placement of sutures. The fascial wings over the bladder spread far laterally, and the bladder and ureter tend to fall farther laterally upon surgical dissection than one might surmise. Therefore, in performing a magnified Wertheim operation, zealous removal of all available cellular tissue in the deep pelvis lateral to the ureter is somewhat hazardous.

Management

With added experience I have become impressed that, with dissection along fascial planes, in the removal of most genital growths the tissues operated on may be made to fall apart and they thereafter fall readily together in completing the operation. Such blunt dissection is inevitably more gentle, and tissues united without tension heal kindly, with lessened distress during convalescence, and a minimum of morbidity and mortality. In this connection I trust that you who are more skillful than I will forgive a suggestion that our patients might be better served by more careful notation of the anatomy, more scrutinizing observation of the pathology, and more deliberate thought concerning the revamped physiology which is to be left in our wake. This does not imply that work may be done without awareness of the fact that wastefulness of time increases morbidity and mortality.

Cases of carcinoma of the body of the uterus, or of the lower corpus or endocervix, likewise cases of pelvic endometriosis, may involve the bladder sufficiently to make hysterectomy hazardous. I shall not dwell on those cases in which resection of the bladder is indicated. In all other such instances the technic is essentially as simple as in the performance of an ordinary hysterectomy if one leaves the bladder undisturbed until the uterus is otherwise freed. Then, with excellent visibility and perfect control, the uterus separates from the bladder without effort, along natural lines of cleavage. With this procedure, as well as in those difficult adherent cases in which it appears expedient to separate the bladder according to the more usual technic, or perhaps with approach from the lateral aspect, methylene blue solution in the bladder is a safeguard.

Let us now consider obliterating lesions of the cul-de-sac with welding of the rectum to the vagina and cervix. It is self-evident that cases of endometriosis in which both ovaries are to be removed require no cul-de-sac surgery. But if one ovary is to be spared, also in cases with other tumorous lesions or cellulitis of the cul-de-sac, dissection of this region may be indicated. Here, analogous to the procedure in cases with a firmly welded bladder, the cul-de-sac dissection may be advantageously reserved for the final step, which makes the technic less formidable, the hazard of rectal injury minimal.

Present-day emphasis on simplification of the technic of complete hysterectomy by generous mobilization of the bladder and, particularly, by freeing the uterus posteriorly and posterolaterally, has militated against our appreciation of other procedures. In cases with firm fixation of the bladder and an immobile rectum, a complete hysterectomy can be accomplished from side to side with facility, and, with greater ease and less hazard; dissection of these viscera may be reserved for the final steps of the procedure, with separation of the more inaccessible viscus last.

Among the reasons for the 50 per cent death rate from corpus cancer are (1) the tendency to tubal spill with extension to the ovary and peritoneum and invasion of the contiguous cellular tissues, (2) extension of lower corpus growths either directly or via the endocervix into the lymphatics of the vascular compartment and cellular tissues of Mackenrodt's ligament. Such extensions are often patently unilateral; those from ovarian growths, tubal carcinoma and endometriosis also may be unilateral. In many such cases the customary simple removal of the uterus and adnexa may advantageously be supplanted by unilateral simple division of the tissues on the uninvaded side of the uterus, with exposure of the ureter and a Wertheim procedure on the side of greater invasion, a "magnified" Wertheim complete eradication of all removable structures resorted to in extreme cases.

A great many years ago we became smugly complacent upon learning that removal of a major pelvic tumor mass often spares life for many years, despite failure to eradicate the growth in its entirety. Now we know that extensive surgery with exposure of the ureter and "housecleaning" of all available cellular structures, usually unilateral, sometimes bilateral, greatly increases the life expectancy of selected patients in this group, even those with an extensive omental cake and implants which are not removed but are controlled by x-ray therapy.

Office Treatment of Gynecologic Conditions

By H. H. CUMMINGS, M. D.
Ann Arbor, Mich.

VAGINITIS in women is commonly caused by the gonococcus, by yeasts or by Trichomonas vaginalis. In this discussion gonorrheal vaginitis will be omitted and only yeast and Trichomonas infections considered. Physicians who have practiced twenty-five or more years will recall the endless stream of women who came to their offices for treatment of a persistent leukorrheal discharge. Week after week, month after month, and often year after year these patients came for the insertion of a tampon soaked in glycerin, boroglycerin, iodine in glycerin, ichthyol in glycerin, or in numerous other combinations. While under treatment they improved but when negligent their symptoms returned. They circulated about visiting each doctor in the community and often sought relief far afield. Cervices were repaired or amputated, hysterectomies done, tubes and ovaries removed, but still the irritating leukorrhea persisted. Only during the past ten years has it become general medical knowledge that minute protozoa, Trichomonas vaginalis alone or in symbiosis with other organisms, and yeasts, often cause a persistent vaginitis.

Trichomonas Vaginalis Vaginitis

Trichomonas vaginalis vaginitis is caused by flagellated protozoa. In its acute stage there is a pale greenish-yellow, odorous discharge from the vagina. This discharge usually contains bubbles. When it comes in contact with the external genitals and the skin, irritated, inflamed, pruritic areas appear. At times these areas may extend far down the inner aspects of the thighs. The vagina shows a generalized redness and numerous small areas of vivid red color. From these spots, which may extend on to the vaginal portion of the cervix, blood appears when they are touched or rubbed. So inflamed is the vagina that vaginal and speculum examinations are often almost impossible. Many of these patients have been told they have gonorrhea.

The diagnosis of Trichomonas vaginalis vaginitis can be quickly and easily made if the patient has not taken a douche for a few days. A drop of the discharge in normal saline solution is placed on a slide and examined under the low power lens of the microscope. The protozoa in their active gyrations are best seen when the light is cut down considerably. These animal parasites are so sensitive that exposure to air by a speculum examination or contact with certain chemicals may cause them to disappear temporarily. This fact has led to the use of a long list of agents: iodine, glycerin, tincture of green soap, alcohol, mercury, arsenicals, dyes, mild acids and numerous other agents. Any or all of these treatments will apparently succeed, though usually when the treatment is stopped the infection returns.

Each worker in this field has adopted a certain plan that in his hands gives fair results; no one has, as yet, announced a sure cure. Failures are due to numerous factors: patients are so improved early in the course of the treatment that they stop the prescribed routine; they become tired of the long, drawn out treatment necessary for a cure, grow careless, and are not seen again until an acute flareup occurs; they reinfect themselves by careless personal habits (fecal contaminations of the vulval tissues) or by intercourse with an infected sexual partner; they fail to treat the condition during the menstrual periods when blood in the vaginal secretions seems to be the most favorable medium for the growth of these protozoa; they neglect the urethra and the urinary tract, where the infection may be harbored and cause reinfection at any time.

In spite of failures many of these patients can be cured. I am convinced that any method suggested thus far will fail if car-

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* Excerpt from a paper presented at the 97th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1938.

ried on by the physician alone. The patient must be instructed carefully about the methods of preventing reinfections and must cooperate with her physician by self-administered home treatment.

Three methods of treatment that have been found useful are outlined here. The Gellhorn method of inflating the vagina and treating all vaginal surfaces with a powder, composed of 12.5 per cent of acetarsone in equal parts of kaolin and sodium bicarbonate, every third day for two weeks. No douches are used during this time. I have supplemented this line of treatment by having the patient insert an acidulated arsenical tablet far up in the vagina. This is done daily in the second two weeks of treatment. Home treatments are continued throughout the menstrual periods, but the arsenical tablets are used less often and office calls are spaced farther apart as the monthly checkups prove that the infection is disappearing or is cured.

A second method of treatment, with silver picrate in suppository and powder form, will cure many cases of Trichomonas vaginalis vaginitis. Office treatments consist of covering the cervix and vaginal surface with silver picrate powder, using a powder blower. The patient uses suppositories containing 1 grain of silver picrate in the vagina twice each week and daily during the menstrual periods. On the days when the drug is not used, an acid douche of acetic, lactic or boric acid is taken. Some patients, however, are irritated by silver picrate.

Karnaky treats trichomonas infections by maintaining a normal acidity of the vagina and a normal bacterial flora. For this purpose he uses slowly soluble tablets of acidulated dextrose containing diiodo-hydroxy-quinoline. One or two moistened tablets are inserted into the posterior fornix night and morning. Acid douches of vinegar or lactic acid are used before the tablets are inserted. Three tablespoonfuls of vinegar or one teaspoonful of lactic acid in two quarts of warm water will produce the proper acidity.

When patients with Trichomonas vaginalis infection continue their treatments for several months they are usually cured. The unimproved must be treated longer, husbands must be examined for the same infection, bacterial investigations made if necessary, and often an associated endocervicitis eradicated, before cure can be effected.

Yeast and Fungus Infections

Yeast and fungus infections cause both vaginitis and severe pruritis vulvae. The vaginal mucous membrane becomes granular and is at times uniformly inflamed. Leukorrhea is not profuse. Some of these patients show white patches that are readily observable. These patches are not easily removed and it is usually necessary to use a dull curet to scrape off material for microscopic examination. If the material for diagnosis is moistened for a few minutes by liquor potassae, the long fine threads of mycelia and oval-bodied spores can be plainly seen. Absence of the white patches of thrush, however, does not exclude yeast infections. At times it is necessary to stain the secretions with dyes to make the diagnosis. Monilial infections are most commonly found in pregnant women and in those who are diabetic.

Fortunately, in yeast infections we have an almost specific therapeutic agent, gentian violet. The use of this dye in aqueous solutions, 1 to 5 per cent in strength, once each day for three or four treatments and then at weekly intervals, quickly eradicates yeast infections. Alkaline douches of sodium bicarbonate seem to hasten the cure.

Endocervicitis

Endocervicitis is found frequently in both parous and nulliparous women. It is the most frequent cause of persistent leukorrhea. It always bespeaks an infection either in an acute, chronic, or healed state. Any organism that attacks the female pelvis may be the causative agent and bacteria associated with the acute infections of childhood can produce an endocervicitis. The gonococcus is the most frequent offender in nulliparous women, while the streptococcus plays the leading role in women who have borne children.

Briefly, the picture of endocervicitis in the acute stage is that of an edematous, swollen,

cervical mucous membrane, very red in color and prolapsing through the external os. A profuse purulent discharge pours out from the glands. As the acute stage subsides the discharge becomes mucoid, or mucopurulent, and is tinged with blood. In the chronic stages the deeper supporting structures are infiltrated. The cervical glands become obstructed and enlarged and retention cysts result. The whole cervix is enlarged, thick and tenacious, and mucopurulent plugs fill the cervical canal. In women who have borne children the picture is altered by cervical lacerations, ectropion, and erosions associated with the infection.

The treatment of endocervicitis in office practice does not necessitate a large amount of apparatus. For the acute stages cleansing douches of boric acid or salt solutions are indicated. Gentle treatments with glycerin tampons will often aid; foreign protein injections into the thighs or buttocks are useful—lactigen and Lakeside protein* given at intervals of a few days will diminish the acuteness of the infection. Active local measures of treatment are contraindicated.

In the chronic stages electrical cautery is indispensable. This does not require an expensive apparatus; only three cautery tips are needed. When the cervix is large and patulous due to cervical tears, shallow, parallel, linear incisions spaced about 3/16 of an inch apart and carried entirely around the cervix will greatly restore the shape of the cervix and reduce the chronic infection. Deeper incisions at the angles or in old tears will cause a rolling in of the tissue and produce a fairly normal looking cervix. A thin cutting tip is needed for this method as advocated by Dickinson. When retention cysts are not too numerous, they can be punctured and cauterized with a small pointed tip. The method most useful in treating endocervicitis is to cauterize over the whole infected area lightly with a cautery tip about the size of a lead pencil. After any of these treatments the cervix is painted with merthiolate or mercresin; the patient is instructed to take a daily saline or boric acid douche and to return in one month. Rarely is it necessary to give more than two or three treatments.

Electrical coning of the endocervical tissues is by far the best method of treating chronic endocervicitis. However, this is not a safe office procedure because of the danger of hemorrhage at the time of operation or secondarily. It is also dangerous because an active, virulent infection may be lighted up if the patient is ambulatory. We are convinced that the place for this operation is in a hospital where the patient is kept for three days and returned home to rest for one week longer.

* Produced by the Lakeside Laboratories, Inc., Milwaukee.

NEW YORK MEETING OF AMERICAN MEDICAL ASSOCIATION

The 91st annual session of the American Medical Association will be held in New York City from Monday, June 10, to Friday, June 14, 1940.

The House of Delegates will convene on Monday, June 10.

The Scientific Assembly of the Association will open with the General Meeting, held on Tuesday, June 11, at 8 p.m.

The various sections of the Scientific Assembly will meet Wednesday, June 12, as indicated below, and thereafter according to their respective programs:

Convening at 9:00 a.m. the Sections on—

Surgery, General and Abdominal.
Ophthalmology.
Pediatrics.
Pharmacology and Therapeutics.
Nervous and Mental Diseases.
Dermatology and Syphilology.
Gastro-Enterology and Proctology.
Radiology.

Convening at 2:00 p.m. the Sections on—

Practice of Medicine.
Obstetrics and Gynecology.
Laryngology, Otology and Rhinology.
Pathology and Physiology.
Orthopedic Surgery.
Urology.
Preventive and Industrial Medicine and Public Health.
Miscellaneous Topics: Session on Anesthesia.

Comments on Treatment

EDITORS
A. J. Quick M. D., Marquette University, Milwaukee
and
M. H. Seevers, M. D., University of Wisconsin, Madison

At the recent meetings of the Federated Societies of Experimental Biology at New Orleans, March 13 to 16, several reports of immediate therapeutic interest and others with possible future application were presented.

Digitalis Glucosides.—Cattell and Gold, of Cornell, compared several purified digitalis glucosides—Ouabain, Digitaline (Nativelle), Digitoxin (Merck), Digilanid C (Sandoz)—with digitalis leaf, on the basis of the frog and cat assays and with respect to their potency in the relief of clinical heart failure. When administered orally, in decompensation, ten units of Digilanid C corresponds in potency to one cat unit of Digitoxin and one cat unit of Digitoxin is equal in therapeutic potency to six to twelve cat units of digitalis leaf. These data demonstrate in a striking manner the inherent dangers in rapid digitalization methods. The cat assay method as well as the official frog method, even though they may parallel the therapeutic potency in the case of a single digitalis compound, lose practical significance as guides to dosage when applied generally to the digitalis glucosides.

Caffeine Withdrawal Headache.—It is common knowledge among habitual coffee drinkers that headache commonly ensues if they are deprived of their regular supply. This observation has been placed on a scientific basis by Dreisbach, of Chicago, who withdrew the drug completely from a group of previously non-habituated subjects, to whom had been administered 10 to 12 grains of caffeine (3 to 5 cups of coffee) daily for one week. In almost all subjects a moderate to severe headache occurred on the day of withdrawal, while in migrainous individuals typical migraine syndromes ensued.

Thrombin.—A more highly purified and concentrated preparation of thrombin has been obtained by Smith and his associates at the University of Iowa. This preparation induces almost instantaneous clotting in shed blood and stops bleeding from small wounds within a few seconds. While as yet unavailable commercially, the material lends promise of being of particular value in operations of the brain, liver and bone, and in the control of bleeding in hemophiliacs.

Urogastrone.—Wieczorowski, Ivy and Gray, of Northwestern University, report a new hormonal principle, urogastrone, recoverable from canine and human urine, which inhibits acid secretion by the stomach. Subcutaneous administration of this material in ten normal subjects reduced the basal gastric secretion, the response to histamine both in regard to volume and acidity, and the total acid secreted. The output of free acid was reduced by 40 to 95 per cent. Further purification of the preparation is necessary because of reactions at the injection site. The material may ultimately be of value in the control of gastric ulcer.

Renal Hypertension. — Two groups of investigators, Page and Helmer of Indianapolis, and Williams, Harrison and Grollman of Nashville and Baltimore, report experiments which offer promise of a new therapeutic approach to the treatment of hypertension. Both groups have obtained extracts of kidney which will relieve the experimental hypertension in dogs and cats resulting from interference with the renal blood supply. It is now postulated that the pressor principle, angiotonin, is antagonized by an inhibitor normally present in adequate quantities in the kidney and possibly in other tissues. Reduction in the availability of this normal inhibitor would then result in hypertension. M. H. S.

THE WISCONSIN MEDICAL JOURNAL

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A DEDICATION

IT HAS been said that if our medical journalism of today were as restricted as that of a century ago, not thousands but hundreds of thousands of lives would be lost because of the simple lack of media for the ready transmission of knowledge. Similarly, he who in the years to come writes a history of the last half century will doubtless feel impelled to point out that the great advances in the health of our people during that period were made possible by men who worked shoulder to shoulder with the scientists.

Those to whom we refer worked in no laboratory. No books have been written about them nor have motion pictures dramatized their successful efforts. They led no crusades on white chargers nor were they inspired by the plaudits of the crowds.

Their way required infinite patience for they led not by command but by education. Untiringly they sought to marshal existing forces that the public might have speedily available the advantages and the protection of constantly improved health procedures. They worked *with* people; they worked *in* and *with* organizations; they worked *with* study and conference groups; they worked *with* legislators,—they worked *for* the health of our people.

If one were to name a man whose life preeminently typifies those here described, none would question our selection of Dr. William Creighton Woodward, M.D., LL. M.

A few lines encompass his official positions which include his twenty-four year term as health officer of the District of Columbia ending in 1918; his succeeding four-year term as health commissioner of Boston; followed by his eighteen years as Director of the Bureau of Legal Medicine and Legislation of the American Medical Association, from which position he retired on January 1, 1940.

Only one who has lived and worked with Dr. Woodward during all those fruitful years could write the volume that would recite his great and good public accomplishments.

Dr. Woodward is learned not alone in the science of medicine, in the realm of law, and in the translation of the advances of science into the protection of the people by law. His is the richer and deeper learning of how to work with men. And because all of this lies in a man of directness, simplicity and public purpose, his contributions to the cause of public health are not to be measured in this generation.

It is with deep respect, esteem, and our best wishes, that we dedicate this issue to Dr. William Creighton Woodward.

William Creighton Woodward, M.D., LL. M.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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Report of Finance Committee

ON THURSDAY, January 18, at the mid-year meeting of the Board of Directors at the Y. W. C. A., Milwaukee, the Finance Committee of the Woman's Auxiliary to the State Medical Society of Milwaukee (composed of Mrs. A. J. McCarey, Green Bay, chairman; Mrs. F. W. Pope, Racine; Mrs. R. E. Fitzgerald, Wauwatosa, and Mrs. E. P. Bickler, Milwaukee) presented the following budget, which was accepted.

The budget allocations for the officers of the Auxiliary and the chairmen of various committee are:

Officers

President	$100.00
Corresponding secretary	3.00
Treasurer	25.00

Committee chairmen

Organization	40.00
Press and Publicity	5.00
Program	3.00
Public relations	3.00
Hygeia	10.00
Archives	5.00
National exhibit	15.00
Philanthropic	2.00
Miscellaneous*	129.00
Total	$340.00

Income derived from two sources:

1. State Medical Society check $100.00
2. Dues from preceding year, the total amount of which shall not exceed 80 per cent of the dues received during the preceding year. The remaining 20 per cent shall be placed in a reserve fund. This 80 per cent is figured on the total amount after the national dues have been paid.

   This year we figured on the basis of 1,200 membership dues 240.00

Total $340.00

* The miscellaneous expense includes the following items: bond for treasurer, board luncheon (mid-year), board dinner (convention date), president's pin, flowers, and incidentals.

It won't be long now before the Woman's Auxiliary to the American Medical Association will be convening at the Hotel Pennsylvania, New York City, for its 18th Annual Convention to be held June 10 to 14, 1940. **Is your reservation in?** We are sure you will want to stay at the headquarters Hotel Pennsylvania. In order to get a reservation, mail your request today to Dr. Peter Irving, Housing Bureau, Room 1036, 233 Broadway, New York City.

Report of Philanthropic Committee

THE Philanthropic Committee was created just last year so, as you may know, its work is still in its early stages. At the beginning of this year there were just three counties that had a philanthropic chairman, although there were many others without a designated chairman who were doing charity work of various kinds. We asked the counties which did not have a chairman if they would name one so as to facilitate the work of the state committee. To date six counties have complied with our request; possibly next year that number may be materially increased. A few of the county presidents replied that their members were so widely scattered through various small towns that they could not work as a group but that they were carrying on individually.

In suggesting ways in which our committee might work, we especially stressed the fact that many good things might be accomplished without the outlay of a great deal of money, and that the interest and participation of each member should enable the auxiliary to increase its helpfulness. Along this line the following things have been accomplished: Old playing cards, in good condition, have been given to institutions for the aged, poor, or, insane; jams, jellies, magazines, books, garden flowers, and vases have been donated to hospitals, sanitariums, and convalescent homes; scrapbooks have been made and dolls dressed for children's wards in hospitals; layettes have been made for service leagues and emergency use; Christmas cards and gifts have been sent to patients in hospitals.

Some of the auxiliaries have been able to do things that entailed more in a financial way, such as purchasing new beds and small chairs for children's use in hospitals. Hair dryers have been given to sanitariums; donations have been made to public health nurses and probation officers; a substantial amount has been given to the Premature Infant and Nursing Bureau to aid in the care and reduction of mortality of premature infants. Each group in this way is endeavoring to fill a particular need in its own community.

The members of the state committee are encouraged by the enthusiastic response from the various counties, and it is hoped that this article may act as a reminder to those counties which have not replied to letters. Let us hope that the work done by each auxiliary may go forward year by year in service and usefulness, thereby increasing the prestige of our organization.

PHILANTHROPIC COMMITTEE,
Mrs. E. F. Andre, Kenosha, *Chairman*,
Mrs. G. C. Schulte, Kenosha,
Mrs. W. E. Buckley, Racine.

A Message From the Auxiliary President

To the Members of the Auxiliary:

Your friendly messages from time to time have been appreciated; I look forward to hearing from you. The interesting programs you are using, I am sure, are benefiting the State Auxiliary. The state chairmen have reported good response from various county chairmen, and I am convinced that with this splendid cooperation we shall advance this year in our work of placing before the public the important information we seek to disseminate.

There was a large public relations meeting in the auditorium of the Woman's Club on April 9, sponsored by the Racine Auxiliary. The speaker was Mr. G. B. Larson, assistant secretary of the State Medical Society of Wisconsin, and the program also included music and tea. Some 225 invitations were issued to various organizations. These invitations entitled the presidents of the organizations who received them to bring one more member from their group. Each high school principal was permitted to bring one instructor; the Woman's Club chairmen, P.T.A. groups, and churches were also contacted. The Racine County Medical Society helped defray the expenses of this meeting.

I am sorry to tell you that Wisconsin did not win first place in the National Hygeia Contest; however, three of our counties received honorable mention (Portage, Sheboygan, and Racine). The Rock and Washington–Ozaukee Auxiliaries reached or exceeded their quotas.

Remember that the National Auxiliary's plans for the convention in New York City are most inviting. It is not too early for reservations if you intend to go. I hope to see many of you there.

MRS. F. W. POPE,
President.

Dane

The members of the Woman's Auxiliary to the Dane County Medical Society met for luncheon Wednesday, February 14, at the University Club, Madison, hostesses being Mrs. W. S. Middleton, Mrs. A. S. Jackson, and Mrs. I. G. Ellis. The program included a brief resume of the January meeting of the Board of Directors of the Woman's Auxiliary to the State Medical Society of Wisconsin by Mrs. H. M. Carter, recording secretary. Mrs. A. S. Jackson read and discussed the Wagner Health Bill and also the article, "The Doctor's Wife," which was read by the author, Dr. Rock Sleyster, president of the American Medical Association, at the annual convention of the State Auxiliary in Milwaukee last September. Mrs. S. J. Briggs read portions of the letter written by Mr. J. G. Crownhart, secretary of the State Medical Society, to the Woman's Auxiliary concerning the Wagner Health Bill.

The resignation of Mrs. W. E. Sullivan as president-elect was read. It was moved, seconded, and carried that this resignation be accepted with regret. The president announced the executive board appointment of Mrs. H. W. Virgin, Jr. to fill the unexpired term.

The March meeting of the Dane County Auxiliary was held at the home of Mrs. H. W. Virgin, Jr., Madison, on the thirteenth. The assisting hostesses were Mesdames H. K. Tenney, A. C. Stehr, P. A. Duehr, L. V. Littig, and C. N. Neupert. A short business meeting followed the one o'clock luncheon.

Fond du Lac

Mrs. O. M. Layton, press and publicity chairman of the Woman's Auxiliary to the Fond du Lac County Medical Society, has reported that plans for an open meeting in April, to be arranged by the public relations committee, were made at a dinner meeting on February 22 at the home of Mrs. A. M. Hutter of Fond du Lac. Assisting Mrs. Hutter as hostesses were Mesdames H. R. Sharpe, L. J. Keenan, and E. V. Smith, Jr. Spring flowers decorated the tables at which twenty-eight members were seated.

The auxiliary voted to give financial aid to the Girl Scout troop which it is sponsoring. During a social hour scrapbooks were made for child patients at St. Agnes Hospital.

Kenosha

In keeping with the program outlined by the national organization, the Woman's Auxiliary of the Kenosha County Medical Society sponsored a symposium on March 15 at the Kenosha Historical and Art Museum, at which time several persons outstanding in the different phases of public health were the speakers. Each gave an interesting resume of his particular line of work, the purpose of the informative symposium being to acquaint Kenoshans in detail with the vast amount of work involved in maintaining public health for the city.

Dr. P. E. Pifer presided over the symposium and introduced the speakers, among whom were Dr. A. J. Randall, city health officer, who told of the many activities of his department and their importance to the citizens. He explained the precautions taken in contagious diseases, how the department assisted physicians with their tuberculin tests, and how it aided the schools in vaccinations and testing for tuberculosis. Another important talk was given by Dr. C. F. Ulrich of Willowbrook Sanatorium, who described the safeguarding of tuberculous persons. Dr. C. G. Richards, who was chairman of the Medical Society's committee assisting in this symposium, also gave a talk, discussing the venereal disease clinic and its work in the community.

La Crosse

Three meetings of the Woman's Auxiliary to the La Crosse County Medical Society have been reported by Mrs. J. C. Harman of La Crosse, secretary.

A regular meeting was held on October 25, 1939, at the Stoddard Hotel, the 6:30 dinner being followed by a routine business meeting. The president, Mrs. E. H. Townsend of La Crosse, then introduced the speaker of the evening, Mrs. F. W. Pope, president of the Woman's Auxiliary to the State Medical Society. Mrs. Pope gave a most interesting and inspirational report of the proceedings of the state organization. Twenty-eight members were present.

The January meeting of the La Crosse Auxiliary was held on the seventeenth in the form of a Silver Tea at the home of Mrs. Gunnar Gundersen, with members of the board of directors and Hygeia committee as assisting hostesses. The sum of $13 was raised and turned over to the Hygeia committee. Members of the Dental Auxiliary and friends were among the seventy-five guests present, who were entertained by a movie travelogue of Norway, taken during the visit of Dr. and Mrs. Alf Gundersen to that country last summer.

On March 13 the members of the La Crosse Auxiliary had the privilege and pleasure of visiting the new Emerson School (orthopedic and elementary) of La Crosse. Miss Josephine Hintgen, principal, conducted the group through the school while it was in session, and the instructors of the various departments made explanatory remarks concerning the work. After a short business meeting, tea was served at the school to the twenty-two members present.

Manitowoc

In January, as is the annual custom, the Woman's Auxiliary to the Manitowoc County Medical Society provided the speaker for the Manitowoc Federation. The members of the auxiliary were invited to meet for luncheon with the Federation, this taking the place of the regular meeting. Eighteen members were present to hear Dr. F. R. Janney of Wauwa-

tosa speak on "How Shall We Counsel Our Children"?

Mrs. L. W. Gregory, Mrs. G. M. Hoffman, and Mrs. N. C. Erdmann of Manitowoc were hostesses at the February meeting. The program included a review by Mrs. W. E. Donohue of the "Biography of J. B. Murphy, M. D." by Loyal Davis, M. D., professor of surgery of Northwestern University Medical School. Following the program the hostesses served tea to the twenty-one members present.

Mrs. T. A. Teitgen of Manitowoc, president elect and press and publicity chairman, also reports that this year the Manitowoc Auxiliary has issued its first yearbook, which contains a list of the officers and committee chairmen, various notices, a statement of the object of the auxiliary, the year's program, and the membership list.

Milwaukee

The Woman's Auxiliary to the Medical Society of Milwaukee County deviated at the March meeting from the usual custom of having a luncheon. The meeting was an educational one, moving pictures on the work of the Milwaukee Children's Hospital being shown in the amphitheatre of the hospital. Miss Alice Olsen, R. N. and Miss Beulah Gautesold, R. N., members of the faculty of the department of nursing of the hospital, discussed entertainment of the convalescent child. The members were especially appreciative of this program.

Great interest has been shown by auxiliary members in the newly organized study group on the National Health Bill, under the able leadership of Mrs. R. E. Fitzgerald. The first meeting was held on March 4, twenty-three members being present. The next meeting will take place preceding the regular monthly meeting on April 12.

The auxiliary welcomes into its membership Mesdames R. T. Hansen and F. C. Heinan.

Racine

The Woman's Auxiliary to the Racine County Medical Society held its March meeting on the twelfth at the home of Mrs. F. W. Pope, of Racine, president of the Woman's Auxiliary to the State Medical Society of Wisconsin. During the business session, which was presided over by Mrs. A. S. Pfeiffer, president, the auxiliary discussed plans for the April meeting. That meeting, arranged by the public relations committee under the co-chairmanship of Mrs. E. W. Schacht and Mrs. I. N. Tucker, will be an open meeting, with Mr. G. B. Larson, assistant secretary of the State Medical Society, as the speaker. Mrs. W. E. Buckley of the program committee then presented Arnold Firks who discussed garden planting.

Tea was served from a table which had a centerpiece of white iris and pink carnations. Mrs. W. C. Roth and Mrs. A. L. Nelson poured. Mrs. C. K. Hahn, Mrs. A. S. Pfeiffer, and Mrs. C. E. Constantine assisted Mrs. Pope as hostesses.

Rock

Mrs. G. S. Metcalf of Janesville, press and publicity chairman of the Woman's Auxiliary to the Rock County Medical Society, has submitted reports of 1940 meetings.

The January meeting was preceded by a 6:30 dinner at the Woman's Club. Following this the Rev. Mr. Kimmel of the Congregational Church of Janesville gave a review of the book "The Nazarene," by Sholen M. Asch.

In February the members met with the physicians of the Rock County Medical Society to hear Dr. N. S. Davis, III, of Chicago, talk on the subject of state medicine. Dr. Davis is treasurer of the National Physicians' Committee for the Extension of Medical Service. There were approximately 100 physicians and their wives present.

Sheboygan

Members of the Woman's Auxiliary to the Sheboygan County Medical Society were guests at a delightful one o'clock luncheon on March 6 at the home of their president, Mrs. W. A. Ford of North Point Drive, Sheboygan. Instead of playing bridge in the afternoon as was originally planned, the members drove to Kohler following luncheon to hear Miss Herma Clark of Chicago speak at an open meeting at the Kohler Woman's Club.

Assisting hostesses at the luncheon were Mrs. H. J. Hansen of Sheboygan Falls and Mrs. O. E. Toenhart, Mrs. W. G. Huibregtse, Mrs. P. B. Mason, and Mrs. W. G. Meier, all of Sheboygan.

Trempealeau—Jackson—Buffalo

The Woman's Auxiliary and the Trempealeau–Jackson–Buffalo County Medical Society held a joint meeting at the Erickson Hotel, Whitehall, on February 15, after which the physicians held a session at the MacCornack Clinic and the members of the auxiliary met at the home of Mrs. N. S. Simons.

Due to the fact that Mrs. F. C. Skemp of Fountain City had been unable to assume the duties of the office of president, Mrs. Simons as president-elect will replace her. Other officers of the auxiliary are: Mrs. Robert Krohn of Black River Falls, president-elect; Mrs. I. K. Krohn of Black River Falls, vice-president; Mrs. R. R. Richards of Blair, secretary; and Mrs. R. L. MacCornack of Whitehall, treasurer.

Winnebago

Mrs. E. F. Cummings of Oshkosh, press and publicity chairman of the Woman's Auxiliary to the Winnebago County Medical Society, has reported a number of interesting and instructive meetings.

The auxiliary secured Dr. J. G. Garland of Milwaukee on January 8 to address the Catholic Woman's Club on "The Early Diagnosis of Cancer." On January 13 Dr. S. E. Gavin, chairman of the Council of the State Medical Society, filled the

speaking engagement of Mr. J. G. Crownhart, secretary, before the Century Club of Oshkosh. The auxiliary had invited Mr. Crownhart to speak on the subject of socialized medicine, but due to illness he could not attend. Dr. Gavin presented an excellent discussion of the subject. The members of the Auxiliary were invited to be present at both these meetings. These joint meetings with lay clubs, at which the auxiliary sponsored the speaker, were enthusiastically received and, in fact, the auxiliary has been requested to encourage similar meetings next year.

In previous years it has been the custom of the auxiliary to omit meetings during the winter months. At the September meeting this matter was discussed, and it was decided that the Oshkosh and Neenah–Menasha groups hold separate social meetings during this season of uncertain weather.

The Oshkosh group held a luncheon meeting at Stein's Restaurant on February 26. Mrs. R. H. Bitter of Oshkosh, president, presided. The speaker was Mrs. Alma Dillon, physiotherapist for the Visiting Nurse Association. She traced the origin of physiotherapy and cited numerous examples of the work and its results. Mrs. Bitter gave a brief report of the January meeting of the Board of Directors of the Woman's Auxiliary to the State Medical Society in Milwaukee. Mrs. S. R. Beatty of Oshkosh became a member of the auxiliary.

On March 12 the Winnebago County Dental Auxiliary entertained the Medical Auxiliary at a pleasant luncheon at the Hotel Athearn, following which Miss Agnes Mattson, superintendent of Sunny View Sanatorium, gave an interesting talk on "The Early Diagnosis of Tuberculosis."

Wood

The Woman's Auxiliary to the Wood County Medical Society was entertained at a 1:30 o'clock dessert-luncheon on March 29 at the home of Mrs. E. J. McGinn of Marshfield. Following a brief business meeting, the group went to the home of Mrs. R. A. Kolb. Here various Indian relics were on display, and Mrs. Kolb gave a talk on "Public Health Nursing Among the Hopi Indians."

Remember the annual convention in Milwaukee in September. Headquarters: Schroeder Hotel. Mrs. Eben J. Carey, chairman.

Society Proceedings

Barron—Washburn—Sawyer—Burnett

The Barron–Washburn–Sawyer–Burnett County Medical Society met on March 5 at the Hotel Cumberland, Cumberland. A talk on "X-ray Therapy," by Dr. Cyrus A. Hansen of Minneapolis, was the main feature of the program. Following his address, Dr. Hansen led a round table discussion on roentgenologic problems.

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society met on March 14 at the Beaumont Hotel Green Bay. Dinner was served at 6:30 p. m. Later motion pictures on cesarean section and perineocolporrhaphy were shown and both subjects were discussed by the forty physicians attending the meeting.

Chippewa

The Chippewa County Medical Society met on March 12 at the Hotel Northern, Chippewa Falls. Two Mayo Clinic physicians, Drs. M. M. Hargraves and F. Z. Havens, were the guest speakers. Dr. Hargraves' subject was "The Practical Relationship of Hematology to Internal Medicine," and Dr. Havens' was "Treatment of Cancer of the Face, Lips and Oral Cavity." Twenty-five attended the meeting.

The society recently initiated a movement in Chippewa county to promote a more sympathetic and better understanding of regulations regarding the visiting of the sick in hospitals.

Dane

The Dane County Medical Society met on March 12 at the Madison Club, Madison. Drs. N. A. Hill and Robert E. Burns, Madison, talked on recent developments in gastroenterology and orthopedics. Dr. A. L. Hoyne, professor of pediatrics, Rush Medical College, Chicago, gave a lecture on "Significant Signs in Contagious Diseases." Refreshments were served following the program.

Douglas

Dr. Richard Bardon of Duluth, Minnesota, was the guest speaker on the program of the Douglas County Medical Society at its meeting on March 6 at the Hotel Superior, Superior. Dr. Bardon discussed "Ulcerative Colitis," illustrating his remarks with x-ray films. At the same meeting the society approved a contract with Douglas county for work in 1940.

Dr. T. J. Doyle, president of the society, reports that twenty-five attended the meeting and adds, "Dr. C. W. Giesen was back with us again after an absence of approximately two months because of illness."

Eau Claire—Dunn—Pepin

The Eau Claire–Dunn–Pepin County Medical Society met on February 26 at the Hotel Eau Claire, Eau Claire. Following dinner at 6:30 p. m., a scientific program was presented. Dr. Bryon E. Hall of the Mayo Clinic discussed "Diagnosis and Treatment of Pernicious Anemia and the Iron Deficiency Anemias," and Dr. Hugh R. Butt of the same clinic talked on "Uses of Vitamins in Clinical Medicine." Dr. H. S. Fuson, Eau Claire, secretary of the society, reports that forty-six attended the meeting.

Fond du Lac

The Fond du Lac County Medical Society held a meeting on February 22 at the Retlaw Hotel in Fond du Lac. Dr. David Cleveland, Milwaukee, was the guest speaker; he discussed "Head Injuries." Fifty physicians attended the event.

Kenosha

The Kenosha County Medical Society met at the Elks Club in Kenosha on February 27, at 6:30 p. m., for dinner and a scientific program. An address by Dr. Francis D. Murphy, Milwaukee, on "Hypertension" was the main feature of the program. Thirty-five members of the society attended the program and the business meeting which followed.

On March 21, members of the Kenosha County Medical Society heard a talk by Mr. Joseph G. Norby, superintendent of the Columbia Hospital, Milwaukee, on "Associated Hospital Service." Twenty attended the meeting, which was held at the Elks Club, Kenosha.

La Crosse

The La Crosse County Medical Society met on March 26 at the Stoddard Hotel, La Crosse. Dr. Fred Pohle, Madison, was the guest speaker. His subject was "The Cause and Treatment of Hypochromic Anemias."

Langlade

The Langlade County Medical Society at its February 7 meeting at the Langlade County Memorial Hospital, Antigo, named Dr. J. W. Lambert, Antigo, secretary-treasurer to fill the vacancy in this office caused by the resignation of Dr. M. A. Flatley, Antigo. The following are presently officers of the society:

President—Dr. W. P. Curran, Antigo
Vice-president—Dr. P. J. Dailey, Elcho
Secretary-treasurer—Dr. J. W. Lambert, Antigo
Delegate—Dr. W. P. Curran, Antigo
Alternate delegate—Dr. L. A. Steffen, Antigo

The society at its February 7 meeting discussed arrangements for the meeting of the Thirteenth Councilor District of the State Medical Society, held in Antigo, March 12.

Manitowoc

The Manitowoc County Medical Society met on February 22 at the Catholic Community Center, Manitowoc. Instead of the customary scientific address, the society heard a talk by Mr. E. T. O'Brien, executive vice president of the Two Rivers Savings Bank, on "Money and Investments." Mr. O'Brien discussed the effect on investments of changes in the gold supply and described the better type of investments. Twenty members attended the meeting.

Marinette—Florence

The Marinette–Florence County Medical Society met on February 21 in Marinette at the Hotel Marinette. Dr. R. S. Irwin, Milwaukee, was the guest speaker. His subject was "Prostatic Diseases." At its meeting on March 6 in Menominee, the society had, as guest speaker, Dr. Paul A. Teschner of the American Medical Association. Dr. Teschner spoke on "Health Education and the Physician."

Milwaukee

The Medical Society of Milwaukee County met at the Milwaukee County Hospital on March 8. The scientific program, sponsored by the society's committee on scientific research, was unusually extensive, featuring six presentations by Milwaukee physicians, as follows:

Howard Correll, M.D.: "The Heart in Myxedema."
Bruno Pietraszewski, M.D.: "Effect of Diet on Nephritis."
F. Peterson, M.D.: "Paroxysmal Hypertension Due to Adrenal Tumor."
David Holman, M.D.: "Erythroblastosis."
James C. Sargent, M.D. and the resident urological staff of Milwaukee County Hospital: "Cryptorchidism."
Armand J. Quick, M.D.: "Contributions of the Laboratory to Clinical Medicine."

Following the program those attending the meeting were guests of the hospital at a social "get-together" and a buffet luncheon.

The speakers' bureau of the society is assisting the Women's Field Army of Wisconsin in supplying physician-speakers to give talks on cancer control before lay groups.

The society is sponsoring four postgraduate clinics on allergy, with Drs. T. L. Squier, H. A. Heise and T. G. Randolph as instructors. The first of the clinics was held April 9.

Pierce—St. Croix

The Pierce–St. Croix County Medical Society met in the Hotel Beebe, New Richmond, on March 21, for dinner and a business session. Eleven were present.

Polk

Members of the Polk County Medical Society were the guests of Dr. L. A. Campbell of Clear Lake on February 15. Dinner was served at the Badger Hotel in Clear Lake at 7 p. m. and then scientific addresses were given as follows: "Group-screening for Tuberculosis," by Dr. A. A. Pleyte, Milwaukee; and "Mt. Washington Sanatorium and Some Problems of Tuberculosis," by Dr. George W. Beebe, Eau Claire. Dr. L. A. Campbell, Jr., Clayton, was elected to membership in the society at this meeting.

Portage

The Portage County Medical Society met on March 13 at St. Michael's Hospital, Stevens Point. A discussion on "What's New in Medicine," was opened by Drs. A. L. Reinardy, Stanley R. Miller and E. E. Kidder of Stevens Point.

Racine

Thirty members of the Racine County Medical Society met at Sunny Rest Sanatorium, Racine, on March 21. They made a tour of the hospital, enjoyed dinner, and then heard a scientific program on the subject of tuberculosis. The speakers and their subjects were as follows:

C. A. Harper, M.D., Madison: "Status of State Board of Health as to Tuberculosis."

A. A. Pleyte, M.D., Milwaukee: "Highlights in Early Diagnosis of Tuberculosis."

G. N. Gillette M.D., Racine: "Modern Treatment of Tuberculosis."

Carl O. Schæfer M.D., Racine: "Review of Thoracoplasties at Sunny Rest Sanatorium."

Rock

An outstanding program, with Dr. Nathan S. Davis, Chicago, treasurer of the National Physicians Committee for the Extension of Medical Service, as speaker, was presented by the Rock County Medical Society in honor of its annual ladies' night dinner at the Hotel Hilton, Beloit, February 27. Dr. Davis' subject was "Can the Government Render Satisfactory and Efficient Medical Service"? Sixty-five attended the program and the turkey dinner.

At the March 26 meeting of the society at the Hotel Monterey, Janesville, Dr. H. L. Greene, orthopedic surgeon of Madison, discussed "Disabilities Following Trauma in Children."

Sauk

The following Baraboo physicians have been elected to serve the Sauk County Medical Society as officers for 1940:

President—Dr. H. J. Irwin

Vice-president—Dr. J. F. Moon

Secretary-treasurer—Dr. C. B. Pope

Sheboygan

A joint meeting of the Sheboygan County medical and dental societies was held February 27 in the Association of Commerce rooms, Sheboygan. Dr. John Gulas, Milwaukee, spoke on "Coordinate Phases of Dental and Medical Practice," and Mr. Alvin Gillette, secretary of the Sheboygan Association of Commerce, discussed "Credits and Collections."

On March 28 the medical society met at the Sheboygan Memorial Hospital to hear a talk by Dr. Albert H. Lahmann of Milwaukee on "Treatment of Common Obstetrical Complications." Discussion and the serving of refreshments followed the lecture.

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met at the MacCornack Clinic of Whitehall on February 15. Dr. R. G. Arveson, president of the State Medical Society, discussed "Problems Confronting our State Society." Eighteen physicians attended the meeting and the dinner preceding it, which was served for the medical society and its woman's auxiliary at the Erickson Hotel. The application of Dr. F. J. Gillette, Mondovi, for membership in the society was accepted at this meeting.

Walworth

The Walworth County Medical Society met in Fontana on March 14. The speaker of the evening was Dr. E. S. Gordon, Madison. He discussed "Endocrinology."

Thirty-two attended the meeting which the society's secretary reports was "one of the most interesting of the year."

Washington—Ozaukee

The Washington–Ozaukee County Medical Society met at St. Joseph's Hospital, West Bend, on February 29. Dr. E. L. Tharinger, Milwaukee, discussed "Criminology and the Doctor." Dr. C. H. Kalb of Grafton, the society's secretary, writes that due to hazardous driving conditions the attendance was not as large as usual.

Winnebago

The Winnebago County Medical Society met on March 7 at the Athearn Hotel, Oshkosh. The speaker was Dr. W. S. Middleton, dean of the University of Wisconsin Medical School, Madison. He led a round table discussion on nephritis. The society's secretary reports "a good attendance."

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine met on March 19. After a business session, the following scientific program was presented:

I. "Postpartum Hemorrhage"
Charles J. Newcomb, M.D.
Discussion: Harold W. Shutter, M.D., Henry J. Olson, M.D.

II. "Sterility"—with special reference to anovulatory menstruation and its response to thyroid and gonadotropic stimulation.

Arthur K. Koff, M.D.—Northwestern University School of Medicine

Discussion: Roland S. Cron, M.D., Benjamin E. Urdan, M.D., George S. Kilkenny, M.D., Frank E. Darling, Jr., M.D.

Milwaukee Gastrointestinal Club

The Gastrointestinal Club of Milwaukee held its annual meeting on February 14 at the Milwaukee Athletic Club. Officers for 1940 were elected as follows:

President—Dr. M. E. Gabor
Vice-president—Dr. R. Bach
Secretary-treasurer—Dr. C. Corcoran

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society met on March 28 at the residence of Dr. Michael Kasak, medical director of the Milwaukee County Hospital for Mental Diseases. On the scientific program, which followed a dinner, Dr. Samuel Wick, Wauwatosa, spoke on "Puerperal Psychoses," and Dr. H. J. Apfelberg, Wauwatosa, on "Syndrome of Progeria."

Milwaukee Oto-Ophthalmic Society

At its meeting on March 12, the Milwaukee Oto-Ophthalmic Society had as guest speaker Dr. W. E. Camp of Minneapolis. Dr. Camp discussed "Histopathology of the Eye."

Wisconsin Society of Pathologists

At a meeting held at the University Club, Milwaukee, on February 19, the Wisconsin Society of Pathologists was organized, and the following physicians installed as officers:

President—Dr. G. H. Hansmann, Milwaukee
Vice-president—Dr. Norbert Enzer, Milwaukee
Secretary-treasurer—Dr. L. J. Van Hecke, Milwaukee
Censors: Dr. Norbert Enzer, Milwaukee; Dr. E. F. Barta, Milwaukee; Dr. L. E. Dickelmann, Eau Claire

The society passed the following resolution:

"This society is opposed to the inclusion of all laboratory and x-ray services and all other medical services in hospital insurance plans, and, further, that hospital insurance should be conducted in accordance with the Wisconsin State Enabling Act."

Thirteenth Councilor District

The Thirteenth Councilor District of the State Medical Society met on March 12 in Antigo. About twenty-five physicians within a radius of seventy-five miles attended.

On the scientific program, Dr. W. S. Middleton, Madison, discussed "Coronary Occlusion" and "Bedside Medicine and the Newer Drugs." Dr. J. W. Gale, Madison, talked on "Diseases of the Breast." And Dr. R. G. Arveson presented an informal address on problems of the State Medical Society. Dr. Arveson spoke under the handicap of injuries sustained in an automobile accident en route to the meeting. Driving in a blizzard over slippery roads, his car turned around twice at Turtle Lake, near Barron, slid down a hill and hit a bridge. Reports have it that the bridge did not yield but that the whole side of Dr. Arveson's Chrysler did. Dr. Arveson suffered shoulder and side injuries.

Following the program, the physicians gathered at the home of Dr. J. W. Lambert, councilor for the Thirteenth District, for a social hour and refreshments.

Physicians Invited to Attend Dinner to Honor Dr. Rock Sleyster, President of the American Medical Association

Under the auspices of the Women's Field Army for the Control of Cancer, Wisconsin unit, a formal dinner to honor Dr. Rock Sleyster, president of the American Medical Association, will be held in the Hotel Schroeder at 7:00 p.m. on Friday, April 19. The speaker of the evening will be Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association. Others on the program are Dr. R. G. Arveson, president of the State Medical Society of Wisconsin, and Dr. Charles Fidler of Milwaukee.

Arrangements for the dinner are in charge of Mrs. G. E. Stoddard, state commander of the Women's Field Army and member of the State Board of Public Welfare. Physicians and their wives are cordially invited to attend; and reservations, accompanied by check at $1.75 a plate, may be made up to and including April 17 with Miss Barbara Merkle, parlor E, Hotel Schroeder.

Among those who will attend the dinner will be state officers of the Women's Field Army, past and present officers of the State Medical Society; the Honorable Daniel Hoan, mayor of Milwaukee; Dr. C. A. Harper, state health officer; Dr. W. D. Stovall, acting superintendent of the State of Wisconsin General Hospital; Rev. Raphael McCarty, president of Marquette University; and Dr. J. P. Koehler, health officer of the city of Milwaukee.

News Items and Personals

Dr. G. A. Hipke, Milwaukee, recently completed fifty years in the practice of his profession. When asked by reporters if a celebration of the anniversary was planned, he replied the program would be "Work, as usual." He is the father of *Dr. Lucius W. Hipke* and *Malcolm M. Hipke*, Milwaukee.

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Dr. J. W. McGill, Superior, spoke on "Health Precautions in Middle Age" at a health forum sponsored by the Superior Cooperative Health Association, February 27. Mr. Bernard Gray, manager of the association, reported on its progress in the last few months. There are now 223 families eligible for benefits in the association.

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Dr. M. Fernan-Nunez, professor of pathology and bacteriology, Marquette University School of Medicine, discussed "Tropical Diseases," before a postgraduate class of pharmacists in Milwaukee, March 20. He stressed the importance of pharmacists becoming acquainted with drugs for the treatment of these diseases, since improved transportation is bringing to this country many maladies formerly regarded as entirely tropical.

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Dr. Mark H. Wall, Superior, was the principal speaker at a recent meeting of the Superior and Douglas county safety council. His subject was "The Safe Treatment of Colds."

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Dr. R. G. Arveson, president of the State Medical Society, addressed 225 members of the Wisconsin Welfare Association at its meeting in Eau Claire, February 10. His topic was "American Medicine and the Welfare Movement."

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"All the professions have problems having to do with increasingly improved service, but these problems cannot find solution through bureaucratic mandate from above," declared *Dr. Eben J. Carey*, Milwaukee, on March 11, when he spoke on compulsory state health insurance before the Northwestern District Dental Society in Chippewa Falls. "Professional men and representatives of the public they serve," Dr. Carey said, "can meet around the conference table and find ways and means and workable solutions." Some 200 dentists, physicians, their wives and guests attended the meeting.

Dr. Carey recently spoke at the annual convention of the Minnesota State Dental Association, St. Paul, Minnesota. While in St. Paul he also addressed the Minnesota section of the American College of Dentists, the St. Paul Association of Commerce and a radio audience.

"Habits of living between 18 and 30 years of age establish the foundation for good or bad health for the rest of a man's life," *Dr. John P. Koehler*, Milwaukee, told members of the Young Business Men's Club of Milwaukee, February 29. Dr. Koehler recently completed his fifteenth year as health commissioner of Milwaukee.

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Dr. E. L. Foreman, chemist at the University of Wisconsin, has recently become affiliated with the *Lakeside Laboratories, Inc.*, Milwaukee.

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The 13th annual William Snow Miller lecture, sponsored by the Wisconsin chapter of Phi Beta Pi, was given on March 25 at the Service Memorial Institute, Madison, by Dr. E. R. Long, professor of pathology and director of Henry Phipps Institute, University of Pennsylvania, Philadelphia. Dr. Long spoke on "The Decline of Tuberculosis."

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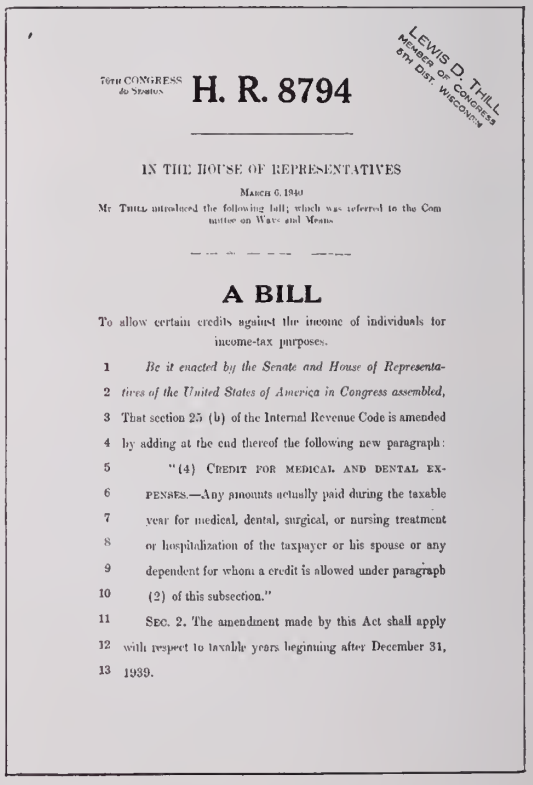
Of interest to Wisconsin physicians is the subject matter of the bill set forth below. It was introduced by the Hon. Lewis D. Thill, representing the 5th congressional district of Wisconsin. It has been referred to the Ways and Means Committee of the House.



LEWIS D. THILL
MEMBER OF CONGRESS
5TH DIST. WISCONSIN

76TH CONGRESS
1st Session

H. R. 8794

IN THE HOUSE OF REPRESENTATIVES

MARCH 6, 1940

Mr. THILL introduced the following bill; which was referred to the Committee on Ways and Means.

A BILL

To allow certain credits against the income of individuals for income-tax purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 25 (b) of the Internal Revenue Code is amended by adding at the end thereof the following new paragraph:

"(4) CREDIT FOR MEDICAL AND DENTAL EXPENSES.—Any amounts actually paid during the taxable year for medical, dental, surgical, or nursing treatment or hospitalization of the taxpayer or his spouse or any dependent for whom a credit is allowed under paragraph (2) of this subsection."

SEC. 2. The amendment made by this Act shall apply with respect to taxable years beginning after December 31, 1939.

Drs. W. P. Curran, E. A. McKenna and *G. E. Moore*, Antigo, spoke on group hospitalization and problems of the medical profession at a joint luncheon meeting of the Antigo Rotary and Kiwanis clubs on March 12. *Dr. R. G. Arveson*, Frederic, scheduled to speak at the luncheon, was prevented from arriving on time because of injuries received in an automobile accident en route to Antigo.

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Many Wisconsin physicians joined Wisconsin dentists in celebrating, March 11–12, the 100th anniversary of American dentistry.

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Dr. F. A. Douglas, La Crosse, spoke on compulsory health insurance at the March meeting of the La Crosse County Community Council.

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The importance of sex education in schools was the subject of an address given by *Dr. E. L. Sevringhaus*, Madison, at the meeting of the Association of Wisconsin State Teachers' Colleges, March 21, Madison. Dr. Sevringhaus also appeared on the program of the Wisconsin Dietetic Association, held in Madison, March 29–30; he discussed "Typical Endocrine Disturbances."

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"A scholarly analysis" was what the Milwaukee Bay View Press termed a talk given by *Dr. J. C. Sargent*, Milwaukee, at a meeting of the Bay View Kiwanis Club, Milwaukee, March 12. His subject was "Socialized Medicine."

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"Graduate Medical Education" was discussed by *Dr. Robin C. Buerki*, superintendent of the State of Wisconsin General Hospital, at a convocation of the University of Wisconsin Medical School, February 29.

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Dr. Donald W. McCormick is now associated in practice with his brother, *Dr. Stuart A. McCormick* of Madison.

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The trustees of Wesley Memorial Hospital, Chicago, have announced the receipt of a $3,000,000 gift which will permit the completion of a new hospital building, the foundations and substructure of which were finished two years ago. The new building will be twenty stories high and will accommodate 525 beds. It is being planned as the first unit in a group of buildings, to be known as the George Herbert Jones Hospital Center.

The hospital is being constructed especially to serve persons of moderate means and so-called white-collar patients, although it will contain facilities for the care of charity patients. Wesley Memorial Hospital is affiliated with Northwestern University, Chicago.

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Dr. Gail R. Broberg, Neenah, spoke on "The Role of Psychiatry in Childhood," at a recent meeting of a Neenah parent–teacher group.

Dr. Frank H. Munkwitz, Milwaukee, attended, on March 10, the 50th anniversary meeting of his medical school graduating class—the class of 1890, Bellevue Hospital Medical College. Presiding at the meeting, held in the Yacht Room of the Hotel Astor, New York City, was Dr. Nathan B. Van Etten, president-elect of the American Medical Association and one of the thirty-five living members of the class, which, originally, numbered 144.

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Dr. J. B. Matthews, formerly of 805 South Fifth Street, Milwaukee, has closed his office and for the present is located at 1231 Serpentine Drive, St. Petersburg, Florida.

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Dr. J. S. Cutler, Wauwatosa, recently passed the half century mark of his medical practice. The Milwaukee Journal, in noting the anniversary, stated: "There aren't many left like 'Doc' Cutler; fifty years of general practice in the country doctor style and still going strong." Dr. Cutler, who is 75 years of age, was graduated from Northwestern University Medical School in 1890.

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Dr. A. C. Edwards of the State Board of Health and *Dr. F. B. Welch*, Janesville health officer, were speakers at a Rock county conference of rural and city health officers on February 29. *Dr. Margaret Hatfield*, Janesville, was in charge of arrangements for the meeting.

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Drs. W. G. Bear and *L. A. Moore*, Monroe, spoke on changes made in Green county since the early days of their practice, at a luncheon meeting of the Monroe Kiwanis Club, February 29. Chief among their recollections of conditions over thirty years ago were difficulties caused by lack of hospital facilities and hardships connected with reaching patients, especially in the spring when "the roads were a sea of mud."

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The New York Polyclinic Medical School and Hospital announces a special lecture by Dr. Russell L. Cecil, professor of internal medicine on April 10, 1940 at 2:30 p. m. on "Pneumonia—The Clinical Status of Classification and Types. Modern Methods of Diagnosis. Rabbit Serum Versus Horse Serum. Discussion of Sulfapyridine and the Newer Sulfonamide Derivatives."

The New York Polyclinic Medical School and Hospital also announces that it has established a special clinic for the hard of hearing. New patients are received on Tuesday and Thursday at 2:00 p. m. The clinic is under the direction of Dr. Samuel J. Kopetzky.

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Dr. A. C. Florin, Fond du Lac, addressed the members of the Fond du Lac Lions Club, March 20, on recent advances in medicine and surgery.

Coming Events

Dr. Paul Phillips, associate professor of biochemistry at the University of Wisconsin, will address the *University of Wisconsin Medical Society* on Tuesday evening, April 30 at 8 p. m. His subject will be "The Pathology of Certain Nutritional Deficiencies."

On May 7, at 7:45 p. m., the regular *Wisconsin General Hospital staff meeting* will consist of a program presented by the department of orthopedics. The meeting will be held in room 230 of the Service Memorial Institute.

The 26th annual golf tournament of the *American Medical Golfing Association* will be held at Winged Foot Golf Club, Mamaroneck, N. Y., June 10, 1940. Winged Foot has two famous championship courses and a beautiful club house. The hours for teeing off are from 7 a. m. to 2 p. m. Sixty prizes, to be awarded in nine events, will be distributed after a banquet at the club house at 7 p. m. Further information concerning the tournament may be obtained from Mr. Bill Burns, 2020 Olds Tower, Lansing, Michigan, secretary of the association.

A clinicosurgical week, under the direction of *The Mayo Foundation*, will be held at the Mayo Clinic, Rochester, Minn., May 6–11. A series of surgical clinics and discussions will be presented, with particular emphasis on the treatment of cancer. Wisconsin physicians are invited to attend.

The 25th annual meeting of the *American Association of Industrial Physicians and Surgeons*, together with the 1st annual meeting of the American Industrial Hygiene Association, will be held at the Hotel Pennsylvania, New York City, June 4–7, 1940. The four-day convention will be devoted to problems of industrial health in all their various medical, technical and hygienic phases, with particular stress on prevention and control of occupational hazards. At a dinner on Thursday evening, June 6, the Wm. S. Kundsen award for the year 1939–1940 will be presented. Further information may be obtained from Mr. Armour G. Park, executive secretary, American Association of Industrial Physicians and Surgeons, 540 North Michigan Ave., Chicago.

The *Section on Radiology of the State Medical Society* will hold its mid-year meeting on the afternoon of Friday, May 17, and the morning of Saturday, May 18, in the Pilot Room of the Stoddard Hotel, La Crosse. *Dr. S. A. Morton*, Milwaukee, is in charge of the program. There will be a dinner, and a ride on the river steamer, The Blackhawk, Friday evening from 6 to 10 p.m.

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Doctors and Physicians in the Census—Enumerators for the Sixteenth Decennial Census, which will be conducted during the month of April, have been carefully instructed by the Bureau of the Census with regard to the listing of doctors and physicians when noting their occupation in the Census of Population.

Instructions to the enumerators include the following:

In the case of a doctor or physician, specify in the Occupation Column the class to which he belongs. If a doctor is engaged on his own account in private practice for fees, enter *private practice* in the column for Industry. If, however, he practices his profession on a salary basis enter in the Industry Column the kind of establishment in which he practices, as *hospital, railroad, steel mill, life insurance*, etc.

The Census Bureau is urging doctors to bear this in mind when giving their answers to the census enumerators. Only careful observation of these instructions will make certain, Census Bureau officials say, that an accurate breakdown can be given on the total number of the different kinds of doctors and physicians on whom figures will be given for the United States, for each of the states, for counties, cities, and towns, and other political subdivisions.

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The *Journal of the Indiana State Medical Association*, March 1940, page 146, states:

"The December issue of the WISCONSIN MEDICAL JOURNAL is very properly called 'Medical Blue Book.' It is a veritable legal guide for Wisconsin physicians for it contains briefs of practically all Wisconsin laws that affect the medical profession. It also has much to say on the subject of office leases, collections, fee splitting, and other interesting topics. The American Medical Association's code is published in full, as are the regulations as to medical licensure in the State of Wisconsin. This very unusual number will afford much pleasure and convenience to the members of the Wisconsin Medical Society."

MARRIAGES

Dr. E. X. Thompson, Milwaukee, and Miss Marion Classen, Milwaukee, March 23.

Dr. Samuel J. Hiller, Milwaukee, and Miss Annette Richman, Milwaukee, March 17.

BIRTHS

A son, William John, to Dr. and Mrs. John F. Cary, Milwaukee, February 20.

A son, Daniel Roman, to Dr. and Mrs. H. V. Malin, Whitehall, January 3.

A son, Jeffrey Martin, to Dr. and Mrs. Frank K. Dean, Madison, March 3.

A son, Frederick Paul, to Dr. and Mrs. A. W. Hankwitz, Milwaukee, March 6.

A daughter, to Dr. and Mrs. T. F. Farrell, Prairie du Chien, in March.

A daughter to Dr. and Mrs. G. R. Hammes, Seneca, in March.

A son to Dr. and Mrs. Richard J. Dietz, Waterford, March 7.

DEATHS

Dr. Henry W. Aldridge, Manitowoc, was killed in an automobile accident, March 21, while vacationing in Texas. He was 68 years of age.

After graduation from the University of Texas School of Medicine in 1898, Dr. Aldridge took up the study of eye, ear, nose and throat diseases. When he moved to Manitowoc in 1915, he specialized in the treatment of these diseases. He practiced in Manitowoc for twenty-five years.

Dr. Aldridge was a member of the Manitowoc County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow and one son.

Dr. Edward J. Barrett, Sheboygan, died on March 9 after an illness of several years. He was 71 years of age. Following his graduation in 1895 from the Cincinnati College of Medicine and Surgery, Dr. Barrett was house physician at the Palmer House, Chicago. He left this position temporarily in 1898 to enlist as a medical officer in the Spanish American War and the Philippine Insurrection.

In 1905 he moved to Sheboygan and remained there until the outbreak of the World War when he again entered military service. In this war he attained the rank of colonel.

On his return to Sheboygan after the war he devoted much of his time to business and to the care of war veterans. He was prominent in the American Legion, holding both state and national offices in the organization.

Dr. Barrett was an honorary member of the Sheboygan County Medical Society and the State Medical Society of Wisconsin. He held membership in the American Medical Association. Surviving him are two sons.

Dr. George H. Conklin, Superior, died on March 11 in a Superior hospital after a brief illness.

Dr. Conklin, who was 74 years of age, was graduated by the University of Michigan Medical School, Ann Arbor, in 1888, and began his professional career in Superior in 1889. He engaged in general practice there until the outbreak of the World War in 1917 when he entered the medical corps. During the war he was in charge of a base hospital in Vichy, France. At the close of the war he took postgraduate work in Chicago and then returned to the practice of medicine in Superior. For many years he was health commissioner of Superior, Douglas county physician, and superintendent of the Middle River Sanatorium.

The doctor was a member of the Douglas County Medical Society and the State Medical Society of Wisconsin. He was a Fellow of the American Medical Association. Surviving him are three grandchildren and a brother.

Dr. Clayton J. Hyslop, Chippewa Falls, died on March 13 after a brief attack of influenza. He was a native of Wisconsin, being born in Blair in 1890.

In 1916 Dr. Hyslop was graduated from Northwestern University Medical School, Chicago. He practiced in Galesburg, Illinois, before locating in Chippewa Falls. Dr. Hyslop was a veteran of the World War. He was a member of the Chippewa County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. Surviving him is his widow.

Dr. Daniel M. Kelly, Baraboo, died on February 27 of cerebral sclerosis. He was 75 years of age.

Dr. Kelly was graduated from Rush Medical College in 1892 and opened an office for the practice of his profession in Baraboo in the same year. He served as mayor of Baraboo for two years and as county physician for twenty-five years.

Dr. Kelly was a member of the Sauk County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow, a son and a daughter.

Dr. Byron O. Nobles, Milwaukee, died on March 24 after an illness of several months. He was born in Ives Grove, Wisconsin, 1863.

Dr. Nobles taught school before he took up the practice of medicine and was superintendent of the Racine county schools, 1889–1890. He was graduated from Northwestern University Medical School, Chicago, in 1893, and in the same year began his professional career in Milwaukee. In recent years Dr. Nobles' chief interest was the operation of a dairy farm in Racine county.

He was a former member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow, one son and a daughter.

Dr. Harry E. Purcell, Madison, died on March 10 in St. Louis of a heart attack. He was en route home from a trip to Florida and had stopped in St. Louis to visit his son.

Dr. Purcell was born in Madison in 1873. He was graduated from the University of Illinois College of Medicine, Chicago, in 1900 and opened his Madison practice in 1901. In 1902 he was elected city health officer of Madison and served in that capacity for several terms. In 1923 he was named citizen member of the Madison board of health and served continuously on the board until his death.

He was a member of the Dane County Medical Society and the State Medical Society of Wisconsin. He was a Fellow of the American Medical Association. Surviving him are two daughters and one son —Dr. Harry K. Purcell of St. Louis.

Dr. Robert Reagles, Madison, formerly of Arlington, died on February 3 in a Madison hospital after an illness of about one year. He was 78 years of age.

Dr. Reagles, a native of Neptune, Wisconsin, was graduated from Rush Medical College in 1894. He opened an office in Ithaca soon after his graduation. In 1909 he moved to Arlington and remained in practice there until his retirement from active practice in 1937.

Dr. Reagles was a member of the Dane County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow.

CORRESPONDENCE

A PATIENT CONSIDERS THE DOCTOR'S READING TABLE

Editor, Wisconsin Medical Journal,
Madison, Wisconsin.

Dear Sir: I found the enclosed letter, accompanied by a set of fashionable magazines, in my reception room. I find the letter so well written and the contents worth consideration that I am sending you the letter. Perhaps you could print it.

Yours very truly,
LUDWIG GRUENEWALD, M.D.,
Sheboygan.

Dear Doctor: We wish to draw your attention to this matter: "Migraine" and I have felt for a long time that the supply of reading material which you furnished for your patients was most inadequate.

A tired housewife coming to consult you does not care to read about the affairs of state or Pontiac automobiles. If she has a good love story to read while waiting, her attitude upon being called into your office will be very pleasant, regardless of how long she has had to wait.

We firmly believe that if you had more variety in your reading material it would do much toward furthering a kindred spirit among your patients.

Since you have always been most kind and considerate of us, we would deem it a privilege if you would allow us to take care of this matter for you, since we have at our disposal the very material which we feel you need. We will keep your table supplied with the latest magazines for men and women if you so desire.

We feel, however, that some fashionable men's magazines should be banned, since they might cause the patient to forget the matter about which he came to consult you. If for any scientific reasons you should like to peruse them personally this could easily be arranged.

Sincerely,
"MIGRAINE" AND "NEURASTHENIA."

"ONE OF THE FINEST THINGS . . ."

Madison, Wisconsin, January 8, 1940.

Mr. George Crownhart,
Secretary, The State Medical Society,
Madison, Wisconsin.

Dear Mr. Crownhart: Thank you for your letter of December 29 and for the accompanying publications. Also may I tell you how much I appreciate the December number of the Wisconsin Medical Journal. It is one of the finest things of that kind I have seen and will be very helpful for reference.

Sincerely yours,
WINIFRED INGERSOLL, M.D.

FUNDS FOR FINNS

FINNISH RELIEF FUND, INC.
Graybar Building
420 Lexington Avenue
New York, N. Y.

The Editor,
Wisconsin Medical Journal,
119 East Washington Avenue,
Madison, Wisconsin.

Dear Sir: The Finnish Relief Fund, Inc., is sponsored by Mr. Herbert Hoover. It is approved by the Finnish Minister in Washington, D. C., His Excellency Hjalmar Procope.

It has the main purpose of accepting for the Finnish people and transmitting to Finland any funds contributed for this great cause by the American people.

Contributions, unless specifically intended to be used for war material, will be used for food and clothing for the Finnish civilian population, many of whom are suddenly made homeless by having their houses irreparably demolished by the incendiary bombs from Russian aeroplanes.

Members of the American Medical Association are the only doctors who will be asked to contribute through this Fund.

It is hoped the profession will respond as generously as possible. It is further hoped that every doctor will make some contribution, and no matter how small it may be, it will be gratefully accepted. We believe the profession should have one hundred per cent of its members become contributors to this most worthy cause.

No money is deducted for expenses from any contribution made through this Fund, and every dollar donated arrives in Finland worth one hundred cents.

The National Chairman of the Medical Division of the Professional Groups of the Finnish Relief Fund, Inc. is Dr. John Frederick Erdmann of New York.

A director (chairman) for the Medical Division has been or will be appointed from each state who will try to get in touch with every member of the American Medical Association of that state by such method as he deems best.

All checks should be made payable to the Finnish Relief Fund, Inc. and sent to the Medical Division of the Finnish Relief Fund, Inc., 420 Lexington Avenue, New York, N. Y.

Thanking you for your cooperation and kindness, I am

Cordially yours,
KERWIN W. KINARD,
Director, Medical Division,
Finnish Relief Fund, Inc.

SOCIETY PROCEEDINGS

New Members

L. M. Morse, 505 North Illinois Avenue, Stevens Point.

P. J. Clark, 20 Forest Avenue, Fond du Lac.

J. J. Simones, 205 South Fourth Street, La Crosse.

L. H. Feiman, 836 West Mitchell Street, Milwaukee.

V. S. Rogers, Bowler.

J. N. Goodman, Veterans' Administration, Wood, Milwaukee.

J. E. Feldmayer, Burlington.

H. C. Marsh, Ison Clinic, Crandon.

M. T. Mitchell, 131 South Barstow Street, Eau Claire.

J. V. Meli, 104 Main Street, Oshkosh.

H. F. Pagel, Ladysmith.

T. W. Walsh, Sauk City.

H. A. Anderson, Pinehurst Sanatorium, Janesville.

F. J. Gillette, Mondovi.

J. F. Kovacic, 308 West North Avenue, Milwaukee.

R. A. Nimz, 8528 Chestnut Street, Wauwatosa.

L. C. Day, Mauston.

D. M. Green, Trust Building, Wausau.

J. D. Zeratsky, 1736 Main Street, Marinette.

G. R. Anderson, 107 North Commercial Street, Neenah.

Haldor Barnes, 1395 Main Street, Marinette.

C. P. Reslock, 20 Forest Avenue, Fond du Lac.

Changes in Address

L. C. Gilman, Osceola, to Atwater, Minnesota.

S. L. Casper, Upper Darby, Pa., to Jefferson Hospital, Philadelphia, Pa.

M. E. Rideout, Hayward, to Wisconsin Veterans' Home, Waupaca.

W. J. Urben, Union Grove, to Milwaukee Asylum for the Chronic Insane, Wauwatosa.

E. E. Grossmann, Milwaukee, to Illinois Eye and Ear Infirmary, Chicago, Ill.

G. E. Hoyt, Milwaukee, to 104 North Fond du Lac Street, Menomonee Falls.

E. J. Shabert, Wauwatosa, to 536 West Wisconsin Avenue, Milwaukee.

H. J. Niebauer, Stevens Point, to Phillips.

S. W. Simonson, Dallas, to Quarters 33, Fort Thomas, Kentucky.

Early Registrations Indicate Large Attendance at Spring Graduate Clinics

RESERVATIONS returned to date indicate that the spring clinics will have a large attendance when they are presented in Wausau on Wednesday, April 24; in Watertown on Thursday, April 25; and in La Crosse on Friday, April 26.

Dr. James A. Evans, designated by the Council on Scientific Work of the State Society to arrange the program for the Spring Clinics, secured such outstanding leaders in the teaching field as Drs. Merrill C. Sosman, Samuel A. Levine, Paul A. O'Leary, Geza de Takats and A. Graeme Mitchell. Members of our own Society who will participate in the clinics are Drs. W. D. Stovall and John W. Harris.

Highlights in the full-day program are: (1) morning clinics in surgery, medicine, pediatrics, and dermatology; (2) afternoon discussions and lectures on laboratory procedures, fluoroscopy, obstetrics, and endocrine disturbances in children; (3) evening round table dinners; and (4) evening lectures on cardiology and roentgenology. In addition to these four outstanding features of the clinic days will be the opportunity each day for members to have a personal consultation with Dr. John W. Harris on obstetrical and gynecological problems.

Round Table Dinners

Those attending the round table dinners last year stated that they offered a splendid opportunity for getting answers to individual questions and urged the Council on Scientific Work to make ample provision for their repetition in the 1940 program. This popular feature has therefore been retained and round table dinner discussions have been arranged on the subjects of obstetrics, medicine, roentgenology, surgery and pediatrics.

Reservations for the dinners should be made in advance on the reservation blank forwarded to each member late in March. If this blank has been misplaced additional reservation blanks may be found at the bottom of pages 260 and 321 of this issue of The Journal.

Question slips will be put at each place at each of the round table dinners. Members may write, on these slips, questions they would like to have answered by those conducting the round table dinner discussions. When the dinner is served the chairman of the dinner meeting will ask that the questions be gathered. These will be answered during and after the dinner.

Meeting Data

The program in each of the three cities will open at 10 a. m. and continue throughout the day, with only slight intermissions, until 10 p. m. A nominal registration fee of $5 has been set by the Council on Scientific Work. This fee will barely cover the costs involved, such as travel expenses of the faculty, hall rental, evening dinners and a small honorarium for the outstanding men who have agreed to participate in the program.

The Marathon, Jefferson and La Crosse County Medical Societies have appointed special committees to make local arrangements. The committee in Wausau has secured the Elks Club of Wausau for the general session and the Wausau Hotel for the dinner round table meetings. The committee in Watertown has arranged for the holding of the general session in the Watertown Elks Club and the round table dinners at the Carlton Hotel, the Elks Club, Otto's Inn and the Wethonkitha Club. The La Crosse committee announces that the general session will be held in the La Crosse Vocational School Auditorium and the round table dinners at the Stoddard Hotel.

The Council on Scientific Work is indebted to the members of the Society who served on local arrangements committees. Those serving on committees in the three communities in which the spring clinics will be held are: Drs. H. P. Bowen, T. C. H. Abelmann and W. S. Waite, Watertown; Drs. H. W. Christensen and E. P. Ludwig, Wausau; Drs. M. A. McGarty, G. F. Malin, and J. C. Harman, La Crosse; and Dr. H. A. Jegi, Galesville.

Members who have made reservations in advance and then find it impossible to attend the clinics, may secure a refund of their registration fee, ***providing they notify the office of the State Medical Society within twenty-four hours before the meeting*** for which reservation has been made.

The program for the clinic days is presented below. Read the program and, if you have not already done so, send in your reservation blank at once. As stated, a reservation blank will be found in the special bulletin mailed you recently or on pages 260 and 321 of this issue of The Journal.

PROGRAM

WAUSAU—April 24

General Sessions—Elks Club
Round Table Dinners—Wausau Hotel

WATERTOWN—April 25

General Session—Elks Club
Round Table Dinners—Elks Club, Carlton Hotel, Otto's Inn, The Wethonkitha Club

LA CROSSE—April 26

General Session—Vocational School Auditorium
Round Table Dinners—Stoddard Hotel

WILLIAM S. MIDDLETON, M.D.
General Chairman and Correlator

10:00 A. M.—Announcements

10:00–10:45 Surgical Clinic
Geza de Takats, M.D., Chicago
Associate Professor Surgery, Univ. of Illinois College of Medicine; Attending Surgeon, St. Luke's Hospital
Treatment of Varicose Veins

10:45–11:35 Medical Clinic
Samuel A. Levine, M.D., Boston
Assistant Professor Medicine, Harvard University Medical School; Senior Associate Medicine, Peter Bent Brigham Hospital
Merrill C. Sosman, M.D., Boston
Assistant Professor Roentgenology, Harvard University Medical School; Roentgenologist, Peter Bent Brigham Hospital
Valvular Diseases of the Heart

11:35–11:50 Recess

11:50–12:30 Pediatric Clinic
A. Graeme Mitchell, M.D., Cincinnati
Professor Pediatrics, Cincinnati College of Medicine
Case of Malnutrition

12:30– 1:00 **Dermatological Clinic**
Paul A. O'Leary, M.D., Rochester
Professor Dermatology and Syphilology, University of Minnesota Medical School
Skin Problem Cases

1:00–2:00 Lunch

2:00– 2:30 W. D. Stovall, M.D., Madison
Professor Hygiene, University of Wisconsin Medical School; Director Wisconsin State Laboratory of Hygiene
(1) Practical Clinical Application of Renal Functional Tests
(2) Clinical Interpretation of Certain Serological Tests in Diagnosis of Communicable Diseases Including Syphilis.

2:30– 3:15 Paul A. O'Leary, M.D.
(1) Oral Bismuth and Its Place in the Treatment of Syphilis
(2) Eczema

3:15–3:25 Recess

3:25– 4:00 Merrill C. Sosman, M.D.
Pitfalls in Gastrointestinal Fluoroscopy
Remarks on Proper Technic in Such Examinations

4:00– 4:45 A. Graeme Mitchell, M.D.
Common Endocrine Disturbances in Children

4:45–4:55 Recess

4:55– 5:40 John W. Harris, M.D., Madison
Professor Obstetrics and Gynecology, Univ. of Wisconsin Medical School.
Management of Some Common Complications of Pregnancy

5:40–6:00 Recess

6:00–8:00 Round-Table Dinners

(All questions to be handed in written on a slip of paper at the beginning of the dinner)

OBSTETRICS
Obstetrical Question Box—John W. Harris, M.D.

MEDICINE AND ROENTGENOLOGY
Medical and Roentgenological Question Box — Drs. Levine, Sosman, O'Leary, Stovall and Middleton

SURGERY
Question Box on Pre- and Post-operative Care—Geza de Takats, M.D.

PEDIATRICS
Pediatric Question Box—A. Graeme Mitchell, M.D.

8:00–8:15 Recess

8:15– 9:15 Geza de Takats, M.D.
Peripheral Vascular Disease

9:15–10:15 Samuel A. Levine, M.D.
Merrill C. Sosman, M.D.
Clinical and Roentgenological Conference in Cardiology

N.B.—John W. Harris, M.D., will be available two hours of each afternoon, the room and hours to be designated at each city, for personal consultation on questions in obstetrics and gynecology.

EARLY DIAGNOSIS CAMPAIGN OF W. A. T. A.

"The x-ray reveals tuberculosis before symptoms appear." This is the theme of the 1940 Early Diagnosis Campaign being conducted by the Wisconsin Anti-Tuberculosis Association and other tuberculosis associations throughout the United States during the month of April. Actually, it is the year-around theme of the organized campaign against tuberculosis, but April is the month chosen to bring it to the particular attention of both professional and lay individuals.

Mortality from tuberculosis is decreasing steadily, but little progress is apparent in the matter of early diagnosis and hospitalization. "Right here in Wisconsin," the W.A.T.A. declares, "only two out of every ten patients entering sanatoriums have the disease in an early stage."

Mass x-ray examination of large groups of seemingly healthy individuals is expensive, often wasteful. However, when dealing with individuals who are sensitive to tuberculin and who for some reason are suspected of having tuberculosis, the judicious use of the x-ray for chest examinations is indicated.

On page 312 of this issue, the W.A.T.A. reports on the use of the fluoroscope as a method of examining tuberculin reactors, to find those needing further study, including x-ray examination of the chest.

What of Our Calling?*

By R. G. ARVESON, M. D.
President, State Medical Society of Wisconsin, 1939-1940
Frederic

Rev. Fr. Berens, Dean Carey of the Medical School, the Faculty, Ladies and Gentlemen:

BEFORE I begin my talk this morning, I wish to say I am deeply and truly honored at being invited to speak here. Let me say also that the State Medical Society of Wisconsin, which I have the honor to represent, through me, brings you greetings and well wishes for your continued prosperity and success.

I have been quite concerned for the past fifteen years with the product which our medical schools have been turning out and I want to talk with you about it. Medicine is having some trouble with society today, and I am wondering whether it might be due to the attitude of our profession.

Twenty-five years ago there were two things that nearly every young doctor acquired for his office as soon as he set himself up in practice: One was the Oath of Hippocrates. The other was a colored picture called "The Doctor." All of you are familiar with it—the sick child in the cabin, the anxious father fingering his hat brim and the mother weeping into her apron. These did not interest the young doctor so much as the central figure did for here was the true physician, long bearded, with Prince Albert coat, chin cupped in his hand regarding the sick child with thoughtful study. Here was what every graduate aspired to be.

Those were the days when the physician was not only the healer but the family counselor, the adviser in finance and marriage, the friend of the family generally. No profession outranked him in popularity—not even the clergy. He was a great, practical man; he did much with his eyes, his hands and his ears. He was above all a good listener. Sitting beside a man in a streetcar and getting a whiff of carbolic acid or iodoform, you realized that you sat near the fountain head of society—the family doctor.

The movies have depicted him as having a great capacity for liquor and much of the general public regarded him as better when under its influence, not too much but just enough. As in other fields of endeavor, this point has been exaggerated. He had a few secrets up his sleeve that did the trick. They have been almost forgotten, but of late men are beginning to use them again. Louis Jermain, who was professor of medicine in this school, used to shake his head when he told of how George Washington was perhaps bled to death. Bleeding went out of style but it is being revived again.

Your own Francis Murphy when he is finally aroused to the height of his subject and talking about right heart failure swings an imaginary knife through the air with the greatest of ease.

Strangely enough if you have read the lives of these men who have gone on before us you will note that they described certain diseases, the description of which has not been improved upon today. Strangely enough the work was done by men, especially in this country, of relatively poor education, some of whom never saw the sixth grade, and yet upon their foundation in thought has arisen American medicine, which is today the greatest in the world. Twenty-five years ago and less was the heyday of medicine in America. It was presided over by great clinicians and I have but to recall a few of them to your minds—Kelly, Halsted, Welsh, Osler, John B. Murphy, Billings and a host of others. Men of the faculty here will recall the day when they sat at the feet of these men and with bated breath drank in every word. I remember well, here in your city some years ago, at the Hotel Pfister, how I listened spellbound to John B. Murphy talk on Colles' fracture for two hours. I could have told all I knew about the fracture in ten minutes or less.

And so, with a long preamble, I have been trying to say that we had a day in the world,

* Address given at Marquette University School of Medicine convocation, Milwaukee, October, 1939.

we older practitioners of medicine, when medicine was practiced as an art. It was a successful practice, the doctor was beloved by his people, his position in society was secure; if the nation had a stomach-ache he was on hand to alleviate it.

So let us leave the doctor in his office with his Prince Albert hung on a hook and his horse tied out at the hitching post swishing off the flies with its tail. Because after all that is where it stopped.

The practice of medicine in its history has been subjected to great trends and directions and many times we have found ourselves going down the street with the procession of society and then having society turn down an alley while we marched on alone, missing the parade.

Human life has nearly doubled in the past hundred years due perhaps to a not too intensively applied preventive medicine, mostly an impersonal sort of medicine; there has been enormous saving of lives in the diseases of infancy and the acute diseases. There has been a shifting of the age structure of the population, so that in 1900, we find one person of sixty years and over in every sixteen members of the population; by 1960 there probably will be one in every six. Think of what that means, one-sixth of the population over sixty years of age. And so growing out of medical advancement we see society affected in that we have social security and old age pensions staring us in the face, the cost of which is and will be staggering. Incidentally it is a peculiar thing in our field that when one disease ceases or diminishes another rises to take its place. As tuberculosis, typhoid and smallpox go down there is a corresponding rise in cancer and the circulatory diseases. Any physician sitting here is well aware of the change in the death rate and the cause of death in the past thirty-five years.

Now the practice of medicine, as we understand it, is divided into two distinct parts: the science of medicine and the art of medicine. We have tried to practice them both at the same time. The public has found us wanting. We have sent men through two and three years of premedical scientific work, then through two years more of scientific work in the medical school, followed by two years in clinical study. Strangely enough, very strangely enough, we rather ridiculed our predecessors who largely graduated from a two-year course in clinical study. The present day doctor approaches the bedside with science as his chief weapon, the art of practice hovers in the background. The sick man is no longer a patient but a case. The patient, to be sure, likes to read about the science of medicine in the Sunday supplement, but when he has a stomach-ache he wants relief. Gentlemen, there is nothing in medicine that will ever take the place of the kindly, thoughtful physician practicing the art of medicine.

One hundred and twenty-five years ago the French broke away from the then accepted theory of medicine. They gave up the old dogmatic style of teaching and began an active type of clinical investigation.

In Germany, the change came a little later, and, following the Napoleonic wars, Germany was wrapped up in idealism and romanticism. In other words they denied factual investigation but rather relied upon speculation. Then the pendulum swung the other way; the results of laboratory studies were put in practice. Johannes Mueller, in Germany, founded the scientific approach as we know it today. Around him he gathered brilliant men as his students, one of whom was Virchow. Berlin became the center of the medical universe. The best of it finally reached this country and research has been a flaming passion ever since.

When I was a student in medical school, Johns Hopkins in our country carried the torch of medical learning and it was presided over by great clinicians. Since that time we have lost ground in the art of medicine. The great clinicians have gone. The public estimation and praise of our work went with them. The medical school today is not judged by how well it turns out doctors able to practice medicine and give relief to suffering people, but upon the eminence of its research. The chairs once occupied by great clinicians with great human understanding are now too often filled by scientists out of

touch with the real problems of the practitioner. I do not say that I want any less medical research, in fact I want more of it, but I would like to see a separation in the teaching, and medical research and medical practice recognized as distinct. The modern medical graduate is turned out skilled in neither. No wonder some loud raucous voice in the rear cries out that he is neither man nor beast.

I think that a man may be a great doctor without being a research worker and I think that often men seeking admission to medical schools, who might make the best of practical physicians, are turned aside in favor of those with a high scholastic preparation in the sciences. This brings to my mind a remark I heard William J. Mayo make: "I wonder where all the smart boys are who were in my class; I never hear of them it seems."

What is education anyway?

Is it possible that England by selective breeding and education has bred a highly developed family of foreign ministers, so much so that they are becoming confused in their own company? Do we not see stalking across Europe an Austrian paperhanger and an upstart in Italy, casting their shadows ominously into every land? They are the bad boys, as it were, but still the practical boys, who seem to go places.

Is the medical profession educating a breed of men, so technically educated, so scientifically minded, so cold and impersonal that the sick individual cries out in despair for a voice of assurance, of hope? Do we not see the cultist, like the bad boys that I spoke of before, making inroads in the practice of medicine, laying on the friendly hand and just elbowing us out of the picture?

If medicine is not going to be regimented it must go back again to its very human interests. In line with the findings of Dr. Edgerton, of the University of Wisconsin, let me tell you what he said about the importance of getting along with people as a factor in the success of the individual. He compared lack of that factor with the quantity zero in mathematics. Zero is a most peculiar number because when a number is multiplied by it, the answer becomes zero. The inability to get along with people, to cooperate with one's associates, is like the number zero. No matter what other accomplishments a person may have in other fields, such as research or technical knowledge, all is nullified and made useless if he does not have the ability to get along with people. This applies of course to anyone who must work with patients, human beings and their nature as he finds it.

I put it up to you frankly, if you were sick tonight, say with acute appendicitis, how would you like to be surveyed by some fellow with a little mustache on his upper lip, rimless glasses and several gold keys dangling from his watch chain, with all the cold impersonality of a goldfish in a bowl?

We point with pride to Jenner as a scientist but he was a bad therapeutist. Koch, whom we venerate, gave up his practice and stayed in his laboratory where he belonged. Louis Pasteur was not even a physician but a chemist. And we honor them all; they were scientists and their discoveries saved untold lives. But there have to be some who can take the discovery and apply it at the bedside. Certainly the discoverers could not. Who was it that said, "You cannot drag the bleeding experiment to the bedside"? He sort of had the idea. And then you remember the story of the alchemist who said to his weeping wife, "dry up your tears, for I have analyzed tears and they are nothing but sodium chloride and water." He was a scientist but he did not possess the great human understanding of women's tears and what causes them.

The permanent basis of medicine is not its research, but its social application—its practice. That has persisted in every age; it will endure in spite of our neglect of it. It can and will rise up to great importance if our public is taught to respect it.

In this talk I have drawn freely upon Dr. Howard W. Haggard of Yale University* and now I would like to quote him direct. He says:

"On one side is research commanding public veneration; on the other is medical practice, a fair target, unprotected by public regard from the

* Haggard, Howard W.: The Social Side of Medical Progress. Minnesota Med. 21: 671–676 (Oct.) 1938.

economic experimenter, the sociological reformer and the political opportunist. What I ask is not any decrease in medical research, indeed every increase, but that medical research and medical practice be recognized as distinct but equally important, equally skilled, equally valuable parts of medicine as a whole. I ask that we may recognize that a physician may be a great doctor without doing original and basic laboratory investigations; that such research belongs to the research investigator and practice to the practitioner. And most of all, I hope that we will go back to training our medical students clinically by great clinicians to be great clinicians."

May I illustrate this division of science and practical application further by saying that during the World War, an officer of the navy was instructing a class of prospective navy officers. Many members of this class were college men and some had done a great deal more work in higher mathematics than had the navy officer who was teaching the class. One day when he gave them a formula which was to be used in some phase of navigation, one mathematician wanted to know the theory back of the formula. His question, in other words, was academic; he wanted to know the derivation of the formula. The instructor answered that he did not know the derivation nor all of the theory, and then he added this very significant statement: "But if you use this formula it will take you where you want to go."

The profession and the senior medical student cry out, "This is a day of specialization." The student proceeds to pick out a specialty in his senior year and after graduation spends some three years in working up his specialty. The office buildings are filled with specialists. But what do the people say? They say that they want a doctor, when they are sick, to treat them; one who knows something about the average illness that the average patient has. They are opposed to too much specialization. But the patient is swept aside and specialization goes on.

Dr. James Sargent made me chairman of a committee that went about this state for a year to determine the adequacy of medical care, for it had been said that the people of this state were not getting proper medical care. I am happy to say to you that we found this statement false. We went into villages, small cities and large cities, and we talked to people of all classes, the high and the low, the scrubwoman and the capitalist, the laborer and the industrialist, and they told us very emphatically that there was too much specialization and not enough of the general practitioner about. They did not like the idea of being shuttled from one man to another. And one can sympathize with their ideas on the subject after considering the number of organs there are in the common order of things. Nowadays each man takes unto himself an organ, and there are lots of them, and proceeds to work upon it. In Minneapolis there is, so I am told, a man who specializes only on the left eye, but I think this is exaggerated.

Is the system of medical education at its best when we are turning out men and women of the same ability, no better, no worse, just like the noses of horses at the starting wire on the track? I remember during the World War we felt that our school system had been lax in America in not preaching an intense nationalism as Europe had done. William J. Mayo himself advocated that the same textbooks be used in Maine as in California so our youth would have the same education. I was for it at the time under war fervor but not now. Think of the drabness of the thing, the sameness. But in medicine today you can gather a thousand graduates together and they will give the same answers every time.

Before I stop, I want to clear myself of the undying hatred of the specialists. I admire many of them and I use them often both to my own and to my patient's good and ease of mind. My address this morning is not without satire. I can, however, still visualize many men getting along nicely with a fine practice and satisfied patients if they will practice general medicine. Is the army to be composed largely of generals and only a few privates? I am interested in the practice of medicine especially its future.

Many of the remarks that I have made are exaggerated but I made them to illustrate my point which is, that possibly and probably we are becoming so scientific that we are missing our target, that of alleviating and curing illness. I have done considerable committee work for the State Society and I have kept in touch with this threat of social-

ized medicine; that is why I am vitally interested in the conduct and education of the profession. What I am saying is not a prepared essay in the matter, rather I am thinking out loud of thoughts that have swept through my mind for several years. I am worried about the attitude of the public toward the profession. Twenty-five years ago if groups had tried to push the profession around as they are today there would have been a near riot. Why? Because the doctor was honored and respected in the family and he practiced largely the art of medicine. Today, however, with the cold detached attitude of the practitioner, we find not many supporters for us in the public. Years ago the family usually had one physician but today they go here and there and in fact the profession talks about it in terms of "shopping around."

We have forgotten that every sick man and his relatives have hope — hope that something may turn up that will affect a cure. Many times we deny him that hope. Last week I talked to the daughter of a man on whom I had operated for cancer of the stomach. This was fourteen months ago and he has lived comfortably since but now he is having symptoms of obstruction. She wanted something done; she asked another operation. I refused. She wanted him sent to Springfield or Philadelphia and packed in ice. I could not advise that. "What about a chiropractor"? she inquired. And so the interview went. When she left, I had taken all the hope out of her, and I felt that, somewhere or other, I had failed. What would you have done? Here was a girl with a great tragedy and I had at every turn made two times two equal four. Too often we drop the case, offer no hope or even consolation and the patient drifts into cultists' hands. The doctor of yesterday would have stood by the dying man until the end. I wonder if the preclinical years might not profit by the addition of more English, history and psychology? It seems to me it would make for better practitioners.

I listened to the Hon. Arthur T. Vanderbilt, president of the American Judicature Society, when he spoke at our annual Medical Society banquet. As he talked about the limited education attorneys possess, except in the law itself, I thought that his remarks could be well applied to our own profession. He said that among his many duties as former president of the American Bar Association he visited many of the leading law schools and had occasion to address the student bodies. He said he never made a very long speech but rather contented himself by asking them questions and then having them ask him questions. He started out by asking them questions that pertained to the background in law, such as how many had read the Magna Carta, the Bill of Rights, the Declaration of Independence, the Constitution, etc. He was greeted with amazement. Less than 5 per cent had read any of them; and yet they were seriously taking up the study of law. Vanderbilt next told the students, since they were not well read in those things, he would ask them questions in literature. He inquired how many had read the Bible as a literary effort, Shakespeare, Chaucer or Wordsworth perhaps. They thought that he was trying to be funny. He replied, if you are down a little on literature, let's try science. And he asked what they knew about Galileo, Watt, Faraday. Then there was indignation.

I have had occasion to employ a number of "well trained" young men coming from good medical schools. They have been trained in science and are not scientists—they know nothing either about the art of medicine. They have only a hazy idea of who Napoleon was. They await the monthly visit of the pharmaceutical detail man like a shipwrecked sailor awaits his rescue. But they are strong for certain tests. Dean Rappleye of Columbia summed up the thing pretty well when I talked to him last year. He told of a friend of his who had a cough for a few days and who while visiting him and playing cards, had a severe chill. They hurried the friend to a hospital. The Dean suggested covering him up with a blanket and putting hot water bottles to his feet, but the house physician waved him aside. After a long series of tests they came to the conclusion that he had pneumonia. The Dean stated it was the custom to take a film, do a blood count, examine the urine, temperature, pulse,

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turn the crank and get the diagnosis. He called it "adding machine" medicine. He was certainly gloomy when I talked to him.

Now let me stop abruptly, for I am wandering, and say to you that I would like to see one thing instituted in this medical school. It deals with the question of human understanding. There is a book written by Ian MacLaren, "Beside the Bonnie Brier Bush." It is the chronicle of the medical practice of one William MacLure of Drumtochty, Scotland. A part of it, the last chapters on the death of MacLure, has been lifted out and the great final chapter has become one of the most deeply moving passages in English letters. It is obtainable now in bookshops as a separate volume.

There is a member of the faculty of one of our great medical schools who each year makes it required reading for his classes. And there is an actor, Walter Huston, who dreams of making a movie out of it with himself as the doctor and Vermont in 1870 as the background—a background not unlike that of mountainous Scotland and the Glen, where Jess (that was MacLure's horse) and the doctor used to make their rounds. Alexander Woollcott says he considers it a part of his job on this earth and his duty each year in one of his radio performances to tell again the story of Dr. MacLure.

Might not its recitation in this school of medicine give faith to the graduate in his very human mission?

"Come, ye blessed of My Father . . . I was sick, and ye visited Me."

Use of the Pfister Fund Fluoroscope Unit in Wisconsin

By E. K. STEINKOPFF, M. D.
Wisconsin Anti-Tuberculosis Association, Milwaukee

LITTLE over a year ago the Wisconsin Anti-Tuberculosis Association inaugurated a new medical service in the form of the Pfister Fund Fluoroscope Unit. Now, at the anniversary of its taking the road, it seems proper for this Association to report to the doctors of Wisconsin on this new undertaking.

Since a considerable part of the organized campaign against tuberculosis is directed toward early diagnosis, every possible means to make diagnoses earlier was scrutinized by the W.A.T.A. When reports began to appear regarding the successful use of the fluoroscope as an instrument for early diagnosis by the medical staff of the Metropolitan Life Insurance Company, much interest was developed among our own medical men.

The reports of Fellows and Ordway on their work among the Metropolitan employees was first made public in Milwaukee at the 1937 meeting of the National Tuberculosis Association. There are two outstanding conclusions among their findings which are worth quoting here: (1) ". . . Sixty-nine per cent of the active cases of tuberculosis are being detected in the minimal stage, twenty-seven per cent moderately advanced and four per cent far advanced." (2) "If one can assume that the x-ray examination reveals 100 per cent of the lesions of pulmonary tuberculosis our results are: revealed by x-ray, 100 per cent; revealed by fluoroscopy, 87 per cent; revealed by physical examination, 36 per cent; revealed by symptoms, 33 per cent."

Other groups, too, using stationary fluoroscope units in localized areas, began publishing reports on the use of this instrument in finding early tuberculosis. Among these were the University of Wisconsin Health Service, the University of Minnesota, and the clinic service of the North Carolina State Sanatorium. The latter, however, used a portable unit built to order.

All this stimulated our desire to develop a plan which would place the fluoroscope at the disposal of the people of Wisconsin in our clinics. Investigation revealed no really portable fluoroscope on the market.

Then one day the germ of an idea appeared. We had a traveling health exhibit

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on the road housed in a large trailer. Why could not the trailer be converted into a traveling clinic equipped with a stationary fluoroscope? This would enable us to provide fluoroscopic clinic service wherever electricity was available. Happily we learned at this time that such a unit was being used by the Anti-Tuberculosis League of Cleveland and Cuyahoga county. After studying the Cleveland set-up, we went ahead with our plan.

Dire and fearful prophesies were made. "The fluoroscope would fall to pieces on the first 50 miles." "People would not come to a trailer to be examined." "We would not be satisfied with it after we had it." These and other words of skepticism and discouragement were heaped upon us. In spite of doubts, however, work progressed, and a fluoroscope was purchased with funds left to the Association by the late Charles F. Pfister, Milwaukee.

In February, 1939, the unit first went on the road examining a group of NYA workers in the Safety Building in Milwaukee. Since that time many varied groups have been examined. These include WPA workers, high school and normal school students, general adult groups, Indians, children at the State Public School and a few industrial groups.

The close of the year 1939 showed 7,853 patients examined. This number has now been increased to over 8,500. Findings listed here, however, will be limited to those made up to December 31, 1939.

Out of this group of 7,853 patients, 391, or 5 per cent, were advised to have further study because of suspicious findings or the tentative diagnosis of pulmonary tuberculosis. Even without further study ninety-eight, or 1.2 per cent, were classified in the group with suspiciously active reinfection tuberculosis. This figure is 4.1 times what we should normally expect to find in the same sized group of an unselected population on the basis of research studies in mortality and morbidity. The study of the Metropolitan Life Insurance Company revealed 1.44 per cent showing tuberculosis, without regard to the presence or absence of activity. Our findings are therefore somewhat higher.

Forty patients were recommended for immediate sanatorium care and thirty-one of these were hospitalized by the close of the year. Eighteen were women; thirteen were men. The majority, totaling twenty-two, were from 15 to 45 years of age. In eight patients the disease was far advanced, in four it was moderately advanced, in seven it was minimal and in four there were active primary lesions. The remainder were under observation or had some extra-pulmonary lesion.

One large group, classified as having only inactive primary infection, made up 2,611, or 33 per cent of those examined. By contrast there were only twenty-nine, or 0.3 per cent, who were classed as having suspiciously active primary tuberculosis.

Two hundred forty-four, or 3 per cent of the patients, showed some other disease than tuberculosis, such as cardiac enlargement, bronchiectasis, or new growth of the lung. Many of these, as well as those with suspiciously active reinfection tuberculosis, were included in the 391 who were advised to have further x-ray study. The largest group, of course, is composed of those in whom the findings were negative. This group makes up 60 per cent of the total.

After checking our records for the past year we are satisfied that this project is worth while. It aids in discovering the early case of tuberculosis. It helps to educate the public and to remove the stigma still attached by some to tuberculosis. Finally, the doctor himself is aided in treating his patient. It is, in short, another development in helping the man on the job to do a better job.

Realizing that the fluoroscope has certain limitations, we emphasize that it is not to be a means of final diagnosis, but rather a screen to select those who need further study because of suspicious findings. Of course, it is possible to make a definite diagnosis in some cases but even these are referred back to their family doctor for this work, which always includes x-ray films of the chest.

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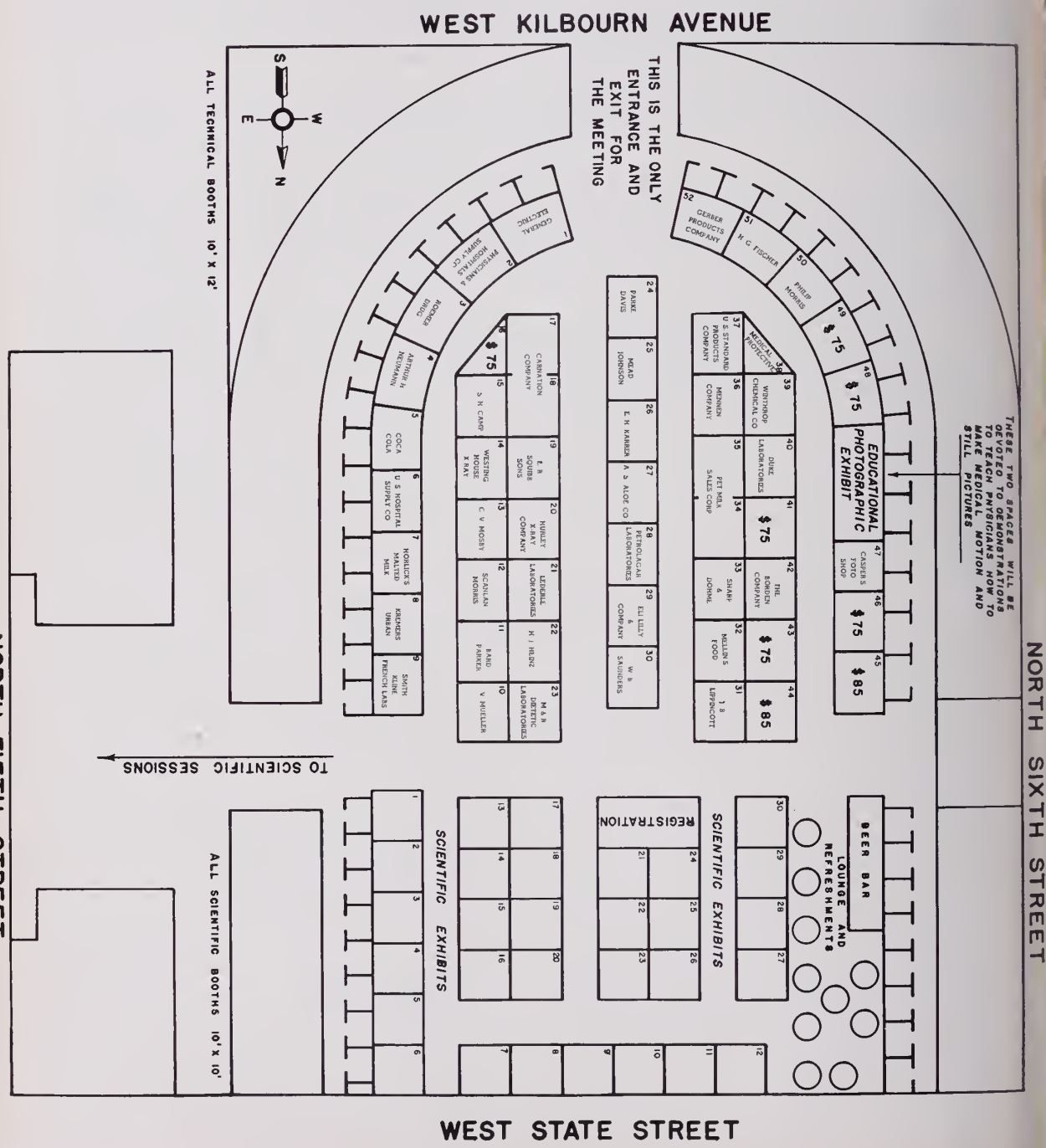
Technical and Scientific Exhibits, 1940 Annual Meeting, State Medical Society of Wisconsin

The diagram below shows the firms that have already reserved space for technical exhibits and the space that will be devoted to scientific exhibits at the 1940 meeting of the State Medical Society. The meeting will be held in the Milwaukee Auditorium, Milwaukee, September 18, 19 and 20.



Army Experience for Physicians

An interesting medical corollary to the augmentation of the United States Army during 1940 and 1941 and to the planned large scale Army maneuvers during the spring and summer of 1940 is the broad medico-military experience which a great number of civilian physicians will receive. Medical Reserve officers are being used to augment the entire Army Medical Service, which includes everything from small unit installations to large Station Hospitals, General Hospitals, and hospitals designed primarily for the treatment of specific types of cases.

Physicians under 35 years of age who are desirous of obtaining extended active duty with the Army but who do not hold Reserve commissions are being offered appointments in the Medical Corps Reserve in the grade of 1st Lieutenant, in order to permit them to be placed on such duty. Captains and Lieutenants are at present being offered excellent assignments throughout the continental United States, and it is hoped that authority will be granted to actually permit some officers to go to Hawaii and Panama. In addition to having a new and very busy experience in the practice of medicine, the average officer finds the pay and allowances attractive. The pay and allowances for a married 1st Lieutenant amount to approximately $263 a month; for a single 1st Lieutenant to approximately $225 a month; for a married Captain to approximately $316 a month; and for a single Captain to approximately $278 a month. In most cases the above pay and allowances would apply inasmuch as Government quarters are not usually available for officers on extended active duty. In the few instances where Government quarters are available, the amounts would be $40, $60, $60, and $80 less per month respectively. In addition, the officer is reimbursed for mileage traveled from his home to his station, and upon completion of his tour of duty is reimbursed similarly for the travel to his home.

Application for one year of active duty, or for appointment in the Medical Corps Reserve with a view to obtaining one year of active duty with the Army, should be requested by a letter addressed to the Commanding General of the Corps Area* wherein the physician permanently resides. In addition, the application should contain concise information regarding permanent address, temporary address, number of dependents, earliest date available for active duty, and that internship has been (or will be) completed; and it should be accompanied by a report of physical examination recorded on the Army Form W.D. A.G.O. 63, which may be obtained from any Army station. From the group of Reserve officers placed on extended active duty since August 1939, over 25 per cent of those within the age requirements of 32 years of age or less for commission in the Regular Army Medical Corps found military service sufficiently to their liking to cause them to take entrance examinations for the Regular Army.

* First Corps Area (Maine, N. H., Vt., Mass., R. I., Conn.) Army Base, Boston, 9, Mass.
Second Corps Area (New York, New Jersey, Delaware) Governors Island, New York.
Third Corps Area (Pa., Md., Va., D. C.) Post Office & Court House, Baltimore, Md.
Fourth Corps Area (N. C., S. C., Ga., Fla., Ala., Tenn. Miss., La.) Post Office Bldg., Atlanta, Ga.
Fifth Corps Area (Ohio, W. Va., Ind., Ky.) Fort Hayes, Columbus, Ohio.
Sixth Corps Area (Ill., Mich., Wisc.) Post Office Bldg., Chicago, Ill.
Seventh Corps Area (Mo., Kans., Ark., Iowa, Nebr., Minn., N. D., S. D.) New Federal Bldg., Omaha, Neb.
Eighth Corps Area (Tex., Okla., Colo., N. M., Ariz.) Fort Sam Houston, San Antonio, Tex.
Ninth Corps Area (Wash., Ore., Idaho, Mont., Wyo., Utah, Nev., Cal.) Presidio of San Francisco, San Francisco, Cal.

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Resolutions on Internship

RESOLUTIONS on internship were adopted by the Advisory Council on Medical Education in February, 1940. The Council is composed of representatives from the following organizations:

Association of American Medical Colleges
American Hospital Association
Federation of State Medical Boards
Advisory Board for Medical Specialties
American College of Physicians
American College of Surgeons
Association of American Colleges
Association of American Universities
American Association for the Advancement of Science
American Protestant Hospital Association
American Public Health Association
Catholic Hospital Association
National Board of Medical Examiners

Wisconsin physicians on the Council include Dr. Robin C. Buerki, Dr. W. S. Middleton, and Dr. W. D. Stovall of Madison.

The resolutions adopted are set forth below:

"Inasmuch as the internship is now universally regarded as a part of the basic preparation for the practice of medicine and to be fully satisfactory must be integrated with the medical course proper, the Advisory Council on Medical Education recommends that the Association of American Medical Colleges in cooperation with national medical and hospital organizations and the Federation of State Medical Boards and state licensing bodies and after consultation with the Council on Medical Education and Hospitals of the American Medical Association should formulate minimum educational standards for the internship and should prepare a list of hospitals in this country which meet these standards.

"Inasmuch as the internship is now universally regarded as a part of the basic preparation for the practice of medicine, the Advisory Council on Medical Education recommends to the Federation of State Medical Boards that an internship of not less than twelve months and of satisfactory educational content be required for admission to the state licensing board examinations in all states.

Basic Principles of the Internship

"1. The internship should be regarded as a part of the basic preparation for either beginning the general practice of medicine or undertaking advanced training in a specialty.

"2. The internship should provide a real educational experience and a period of clinical responsibility under supervision which aims to complete the clinical clerkship of the medical course.

"3. The internship should be an important responsibility of the staff and be under the direction of those members who are competent to provide the necessary instruction.

"4. The internship should be a joint responsibility of the medical schools and of those hospitals which can provide a satisfactory completion of the fundamental preparation for medical practice.

"Believing that the public interest as well as that of the medical profession and of medical education would be served by a satisfactory method of interstate endorsement of licensure, the Advisory Council on Medical Education recommends to the Federation of State Medical Boards that all state licensing boards endorse without further examination the licensure of an applicant previously obtained by examination in another state whose standards of education and examination are not lower than their own, provided that the applicant is a graduate of a medical school in the United States and its possessions which at the time of his graduation was on the list of approved medical schools.

"Recognizing the widening public, cultural and educational interests of medicine, the Advisory Council on Medical Education recommends to the Association of American Medical Colleges, the Association of American Universities and the Association of American Colleges that the college preparation for medical studies above the necessary grasp of the fundamental principles of biology, physics and chemistry should be devoted to general education rather than additional forms of preprofessional education."

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Recent Advance in Roentgenographic Study of Large Groups

Development of a reasonably accurate yet relatively inexpensive method of applying x-ray examination to large groups of people in tuberculosis case finding was described in a paper delivered before the Radiological Society of North America at its Atlanta meeting in December, 1939. Authors of the paper were Drs. Hollis E. Potter, of Chicago, and Bruce H. Douglas and Carl C. Birkelo, of Detroit.

Reporting on a study of 1,610 cases, in which both regular 14″ x 17″ radiographs and 4″ x 5″ photographs of the fluorescent image were made for comparative diagnosis, their method of photo-roentgenography was characterized as a "type of examination which can be applied . . . to large numbers rapidly and economically," having "definite advantages over certain other x-ray methods," which "can be applied directly without preliminary tuberculin testing," and which "offers a practical method for case finding in tuberculosis for use in surveying large numbers in susceptible groups."

After giving recognition to the work previously carried on by others in an effort to achieve a similar objective, the authors pointed out that Dr. Potter, in consultation with the General Electric X-Ray Corporation laboratories, after much study and experimentation arrived at the conclusion that the most desirable objective in photography of the fluorescent image should be to produce a small film, small enough to make a real economy in its use, and yet large enough to be readily interpreted without enlargement, or at least no greater enlargement than that provided with a simple reading glass.

Working on this basis it was found that a 4″ x 5″ film with an effective focal range slightly smaller than this would answer the requirements. Special equipment was therefore designed by the General Electric X-Ray Corporation for producing such photo-roentgenographs, according to the discussion.

The technic of producing this film requires a modern x-ray installation with capacity to permit exposures of from 20 to 80 milliampere-seconds at from 60 to 80 kilovolts, an impulse timer, and a tube-screen distance of 50 inches or 125 centimeters — thus producing as little distortion as possible.

The fluorescent screen used is nearly seven times as fast as the regular fluoroscopic screen. The lens is also a specially prepared instrument with a rating of F. 1.5, and is mounted in a tunnel with the screen at the opposite end so that both can be moved up and down to adjust to the proper level for a patient standing upright. This lens is capable of producing a very sharp image in an area of about 3.7 inches in diameter on the 4″ x 5″ film.

On the basis of careful calculations and actual records it was estimated that the cost of materials only for 4″ x 5″ photo-roentgen films was about one-tenth that for regular 14″ x 17″ radiographs of the chest.

Comparing the new method with other means of group survey work, Drs. Potter, Douglas, and Birkelo pointed out that, in common with other x-ray methods, it requires only one visit by the patient while several may be needed for complete tuberculin testing, results in a permanent record, is more acceptable to patients, and provides a means of detecting other non-tuberculous lesions of the heart and lungs. They state it is more economical than the use of full size radiographs, is less expensive and easier to handle than sensitized paper, and more accurate than fluoroscopy alone.

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BOOKS RECEIVED FOR REVIEW

Ten Years in the Congo. By W. E. Davis. Cloth. Price, $2.50. Pp. 301. New York: Reynal & Hitchcock, 1940.

Trapping the Common Cold. By George S. Foster, M.D. Manchester, N. H. Cloth. Price, $1.25. Pp. 125. New York: Fleming H. Revell Company, 1940.

The Newer Nutrition in Pediatric Practice. By I. Newton Kugelmass, B.S., M.A., M.D., Ph.D., Sc.D., attending pediatrician, Broad Street Hospital and Heckscher Institute, New York; consulting pediatrician, Lynn Memorial Hospital, Monmouth Memorial Hospital and Muhlenberg Hospital, New Jersey. Cloth. Price, $10. Pp. 1155, with 183 illustrations. Philadelphia: J. B. Lippincott Company, 1940.

Dependable Modern Treatments for Burns. By Harold Joe Davis, safety engineer. Paper. Price, 50 cents. Pp. 9. Beebe, Ark.: Underhill Press.

Management of Obstetric Difficulties. By Paul Titus, M.D., obstetrician and gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; consulting obstetrician and gynecologist to the Pittsburgh City Homes and Hospital, Mayview, and to The Homestead Hospital, Homestead, Pa.; secretary of The American Board of Obstetrics and Gynecology. Ed. 2. Cloth. Price, $10. Pp. 968 with 368 illustrations and 5 color plates. St. Louis: The C. V. Mosby Company, 1940.

Physical Diagnosis, Elmer and Rose. Revised by Harry Walker, M.D., F.A.C.P., associate professor of medicine, Medical College of Virginia, Richmond, Va. Ed. 8. Cloth, Price, $8.75. Pp. 792, with 295 illustrations. St. Louis: The C. V. Mosby Company, 1940.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

A Textbook of Pyretotherapy. By Willa Phillips, R. N. Paper. Price, $2. Pp. 83, illustrated. Ann Arbor, Mich.: Edwards Brothers, Inc., 1939.

This book of 84 pages is written by a nurse for nurses as a guide in the administration of fever therapy. The author stresses the fact that this is not only a fairly new procedure but also a serious one which must be borne in mind at all times by those responsible for the welfare of the patient undergoing fever therapy. The essential phases of the subject are covered; as a matter of fact one may well consider certain parts as a treatise for physicians since material of a more or less medical nature has been included. Your reviewer recognizes the difficulty in drawing the line too sharply. However, whether or not the requirements for the training of the physician directing fever therapy and his qualifications for this work should have been included is perhaps a matter of opinion. E. A. P.

An Introduction to Gastro-Enterology. By Walter C. Alvarez, M.D., professor of medicine, University of Minnesota, The Mayo Foundation, and a senior consultant in the Division of Medicine, The Mayo Clinic. Ed. 3 of The Mechanics of the Digestive Tract. Cloth. Price, $10. Pp. 778 with 186 illustrations. New York: Paul B. Hoeber, Inc., 1940.

As a sequel to "The Mechanics of the Digestive Tract" this book should be received even more favorably than its two predecessors. It really is a new book with a new title rather than a third edition. Seven new chapters have been added along with the material from some 1,500 new articles.

The title "An Introduction to Gastro-Enterology," is most appropriate, for the book is primarily a text on physiology. What better approach could be made to a consideration of diseases of the gastrointestinal tract than the physiologic, especially since most symptoms referable to the digestive organs arise from mechanical or motor disturbances of function? It is of importance that the clinician have a primary knowledge of normal and disturbed motor behavior before he can understand the implications of structural changes due to disease. The author repeatedly compares our present state of knowledge of the modus operandi of the digestive organs with that of the heart a generation and a half ago. His contribution is unique not only because he has pointed out this lag, but also because of the technic used in presenting the subject matter. In this field there is so much more theory than established fact that the continual presentation of opposing opinions raises more questions than are answered. Therein lies an interesting and stimulating feature of the text, making it difficult to set it aside.

So exhaustively has the field been covered that a large book has been necessary for completeness. Each chapter, however, is carefully summarized so that, for the reader with some knowledge of the subject, it is read quickly.

Written for the specialist in gastroenterology this book should be equally interesting and valuable to the clinician, the physiologist, the research worker, and the surgeon: of value to the clinician for its presentation of fundamentals; of value to the physiologist for herein are gathered the important works of the world on the motor function of the digestive organs; of value to the investigator for the questions it raises; and of value to the surgeon as a guide in his procedures.

Several other notable features characterize the book. The author writes with an ease and facility possessed by few writers on scientific subjects. Throughout the entire book he makes continual references to the work of others and appends a bibliography of over 100 pages containing references

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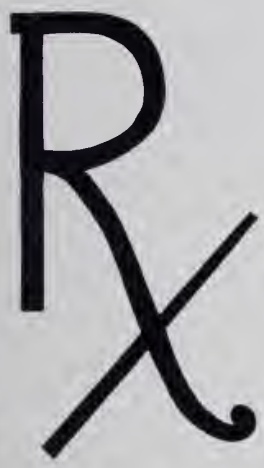

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to several thousand articles. Where illustrations serve his purpose better than the written word, he uses them. K. L. P.

Pneumoconiosis (Silicosis): The Story of Dusty Lungs. By Lewis Gregory Cole, M.D., director of silicotic research, John B. Pierce Foundation, New York City, and William Gregory Cole, M.D., New York City. Cloth. Price, $1.00. Pp. 100, illustrated. New York City: John B. Pierce Foundation, 1940.

As the authors state, this volume has been prepared to record the observations and conclusions arrived at after a short but intensive investigation of pneumoconiosis. Their study commenced in 1935. The senior author, later aided by his son, commenced, with little previous knowledge and a few preconceived ideas, to study sections of diseased lungs and record the findings in detail. Later, studies of roentgenograms were made.

In this work particular emphasis has been placed upon pathogenesis, pathology, roentgen ray findings and social and economic aspects of silicosis. By dark field studies the authors indicate that they have demonstrated accumulations of flecks of various types in the lungs which they consider extremely important. They go on to describe the pathology in detail and offer a fourth type in the classification of silicosis.

There are several viewpoints which are in disagreement with those of most students of silicosis. Thus, as the authors state, their conception that dust flecks cast shadows on the roentgenogram is decidedly unorthodox. They suggest, but do not conclude, that the silicotic nodule may not be caused by silica. There is reinterpretation of the significance of the areas of over aeration in silicosis believed by most to be emphysematous in character. The authors are especially critical of the limitations of the definition of silicosis as given by the Committee on Pneumoconiosis of the Industrial Hygiene Section of the American Public Health Association, particularly of the inference that nodules must be present. They argue that their type IV, acute silicosis, without nodulation, is unjustly non-compensable because of the limitations of the definition.

There is an interesting discussion regarding the causes of dyspnea in silicosis, but the tenets of the authors are not proved.

Although the professed beliefs of the authors are interesting, they probably will be hard-put to convince skeptics of the majority of their claims, for incontrovertible proof is lacking as yet.

The book itself is written in a forceful style, but in a more informal one than is usual in medical works. In the body of the volume there are no illustrations whatever. This is unfortunate. Numbers are given for a reference and as the roentgenograms, photomicrographs and microscopic secretions are at the Pierce Foundation filed under these numbers, they are available to those who are interested. Most cannot avail themselves of this opportunity and the lack of illustrations with the text makes reading of the subject matter more difficult than would otherwise be the case. The appendix comprises two reprints published in 1939. These contain good illustrations, however, and reference may be made to these. Much of the material in the reprints is also in the principal section and therefore there is considerable repetition.

Students of silicosis not already familiar with these investigations will be interested in this publication. Physicians with but a casual interest in the field will probably consider the subject more complex than they had hitherto thought after study of this volume, and some of the material presented may tend to confuse the uninitiated. O. O. M.

Shock: Blood Studies as a Guide to Therapy. By John Scudder, M.D., Med. Sc.D., F.A.C.S., from the surgical pathology laboratory of the College of Physicians and Surgeons, Columbia University, and the department of surgery, Presbyterian Hospital, New York City. Cloth. Price, $5.50. Pp. 315, with 55 illustrations and five plates three of which are in color. Philadelphia: J. B. Lippincott Company, 1940.

For one interested in the historical development of the conception and treatment of shock this volume is invaluable. The tabular presentation of the history of shock, the physiologic and toxicologic effects of potassium, and the functions of the adrenal glands are both valuable and unique. There is also a very useful bibliography.

The author is particularly interested in the electrolytic changes associated with shock. One common denominator in the phenomenon of shock, whether produced by tissue abuse, loss of fluids, hemorrhage, injection of toxins, destruction of the adrenal cortex or stimulation of the sympathetic nervous system, is a rise in plasma potassium. In clinical cases due to operation, trauma, burns or perforations of the intestinal tract, there were no survivals if the plasma potassium had increased over 100 per cent. The author does not mean to state that shock is potassium poisoning. The increased potassium in the plasma comes from the profound cellular changes which underlie shock. Potassium is freed by cellular injury since the amount of intracellular potassium is high.

Although red blood cell counts and estimations of hemoglobin are used in measuring hemoconcentration in shock, the author believes that determining the specific gravity of peripheral blood is superior because of its speed and accuracy. Both changes in venous pressure and specific gravity precede the fall in blood pressure by many hours.

The efficacy of transfusion is granted but it is best combined with injections of salt solutions. In treating twenty-seven cases of shock in moribund patients, who had failed to respond to the usual restorative measures, the author reports a survival rate of 52 per cent with injections of eschatin and salt solution. The cortical hormone is believed to restore the electrolytic balance, increase the blood volume, raise the blood pressure and restore kidney function. The benefits of the salt solution are attributed to combating the hemoconcentration, increasing the velocity of the circulation, decreasing vaso

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constriction and lowering the potassium concentration. In the reviewer's opinion the fact of capillary damage and the danger of increasing further filtration by reducing the osmotic pressure of the blood are not sufficiently considered.

The book is beautifully printed. There are many illustrations and charts. Many clinical cases are given in great detail. W. J. M.

Demonstrations of Physical Signs in Clinical Surgery. By Hamilton Bailey, F.R.C.S. (Eng.), surgeon, Royal Northern Hospital, London; surgeon and urologist, Essex County Council; surgeon, Italian Hospital; consulting surgeon, Clacton Hospital and the County Hospital, Chatham; external examiner in surgery. University of Bristol. Ed. 7. Cloth. Price, $6.50. Pp. 310, with 377 illustrations, some in color. Baltimore: Williams & Wilkins Company, 1940.

This is an instructive book for the student who is learning surgical diagnosis. There are many signs presented which are not found in the standard texts on physical diagnosis. The illustrations are excellent, and demonstrate the signs exceptionally well. The accompanying texts, in most cases, make no attempt to explain the physical or pathological basis for the signs, which I feel puts this volume in the class of an atlas rather than a textbook. While this is obviously the author's intent, as stated in chapter I, this volume is incomplete unless used along with some text which does explain the "basis" for the signs. With this reservation in mind, the book is recommended to students in surgery, interns, and surgical house staffs. K. E. L.

Psychopathia Sexualis: A Medico–Forensic Study. By Richard Von Krafft–Ebing, M.D., professor of psychiatry and nervous diseases, University of Vienna. Cloth. Price, $3. Ed. 12. Pp. 626. New York: Pioneer Publication, Inc., 1939.

In spite of the fact that the original book was written over fifty years ago, it continues to be the best reference book for the study of sexual pathology. The great variety of inversions and perversions described by the author really make this book an encyclopedia. The men who have followed Krafft–Ebing very properly have described him as the "pathfinder in the field of modern sexual pathology." The counterpart of many of our present day sexual crimes is to be found herein. The apprehension, proper hospitalization, and more critical study of these sex offenders would terminate the sordid front page stories found in the press.

The legal aspects of the proper dealing with abnormal sexual behavior is admirably handled. Because of the scientific soundness of the discussions and judgments, this book should continue to be the criterion for our opinions today. W. J. B.

Manual of Fractures, Dislocations and Epiphyseal Separations. By H.C.W.S. de Brun, M.D., F.A.C.S., adjunct professor of surgery, New York Polyclinic Medical School and Hospital; associate visiting surgeon, Swedish Hospital, Brooklyn, N. Y.; consulting skeletal surgeon, New York Police Department; late chief of clinic, Reconstruction Hospital, New York City. Cloth. Price, $3. Pp. 468, with 150 illustrations. Chicago: Year Book Publishers, 1940.

In this book we have a concise, economical handbook of fractures. It should be especially valuable to medical students and general practitioners who desire a brief fundamental outline of the subject. It would not be of great aid to one doing a great deal of fracture work either for specific diagnosis or for detailed procedure.

Fractures and dislocations are discussed largely in outline. In most cases several forms of treatment are listed with their respective good and bad points. There is a paucity of illustrations and x-ray reproductions. However, by definition, these are necessarily omitted because of space and size limitation. Follow-up care is directed to avoid confusion. The discussion on roentgenological diagnosis is very valuable but includes few illustrations.

The book should fulfil a need for those desiring just such a manual, especially students. J. E. M.

Directory of Medical Specialists Certified by American Boards. Edited by Paul Titus, M.D. (directing editor), and J. S. Rodman, M.D. (associate editor). Cloth. Price, $5. Pp. xv + 1573. New York City: Columbia University Press, 1940.

This Directory lists approximately 14,400 diplomates certified by the twelve special american boards and one of the two affiliate boards.

A separate section is devoted to each american board, with both a geographic and a biographic listing of its diplomates. In addition, there is a complete alphabetic list of all the 14,400 diplomates. In this list there are addresses and indications of specialty certification, while in the geographic sections complete biographic information is given. The organization and examination requirements of each of the american boards are explained in full.

All these features make the Directory unique and invaluable to doctors, (specialists or general practitioners), hospitals, social agencies, libraries, medical societies, business organizations, etc. It will help hospital officials pass on the ability of candidates for staff positions. It will provide medical society officers with authoritative lists. Family physicians can form an accurate judgment of the qualifications and ability of specialists in any branch of medicine for the benefit of patients.

Contents: Introduction; List of Abbreviations; Biographical List of Diplomates by State and City; Advisory Board for Medical Specialties; The American Board of Anesthesiology; The American Board of Dermatology and Syphilology; The American Board of Internal Medicine; The American Board of Obstetrics and Gynecology; The American Board of Ophthalmology; The American Board of Orthopaedic Surgery; The American Board of Otolaryngology; The American Board of Pediatrics; The American Board of Plastic Surgery; The American Board of Psychiatry and Neurology; The American Board of Radiology; The American Board of Surgery; The American Board of Urology; Alphabetical List of Diplomates.

(Continued on page 326)

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*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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Injection Treatment of Hernia, Hydrocele, Ganglion, Hemorrhoids, Prostate Gland, Angioma, Varicocele, Varicose Veins, Bursae and Joints. By Penn Riddle, B.S., M.D., F.A.C.S., assistant professor of clinical and operative surgery, Baylor University, College of Medicine; director of the Varicose Vein Clinic, Parkland Hospital, Dallas, Tex. Cloth. Price, $5.50. Pp. 290 with 153 illustrations. Philadelphia: W. B. Saunders Company, 1940.

This book on injection treatment by Penn Riddle is the first attempt to gather all the information dealing with the injection treatment into one volume. The section on injection treatment of hernia adds nothing new with the possible exception of the chapter on trusses which is important. The end result shows the percentage of cures to be much less than in most published works to date. This I feel is a more correct evaluation of the results of the treatment than has been given elsewhere. The section on injection of varicose veins and hemorrhoids gives all the necessary information to treat these conditions. There is still some question as to whether ganglion, bursa and angioma and the prostate gland should be treated by this method. This book is recommended to those interested in obtaining the latest information in regard to the injection treatment. K. E. L.

Fourth Saranac Laboratory Symposium on Silicosis. Edited by B. E. Kuechle, vice president and claims manager, Employers Mutual Liability Insurance Co., Wausau, Wisconsin. Paper, Pp. 379. Wausau, Wis.: Employers Mutual Liability Insurance Co., 1939.

Five years ago the Saranac Laboratory first became host to a Symposium on Silicosis. A program of clinical, experimental and public health subjects was presented by experts in each field from various places in the United States. An enrollment of physicians and lay-workers was carefully limited to produce a maximal educational effect and to prevent unscrupulous use of the information. (It is interesting to know that almost one-third of the group was from Wisconsin, and that five representatives of the Industrial Commission attended.)

The published papers of the Fourth Symposium are now available. The early high standard has been maintained, and the broad field of silicosis has been remarkably covered by a series of thirty-eight reports. Such experts as Dr. Gardner (in charge of the Saranac Laboratory), Professor Drinker of Harvard, Dr. Sayers and Dr. Lanza of United States Public Health Service, Dr. McCann of Rochester, Drs. Riddell, Vorwald, Sampson, Pendergrass and others have written on one or more phases of their various specialties. Wisconsin is represented by Dr. O. A. Sander, by Mr. Voyta Wrabetz, and by a report of the Wisconsin Physical Examination Program.

New material is presented in spite of the recent series of four monographs prepared by a national committee for the United States Public Health Service. This is at least in part because of the surveys made in dolomite, gypsum, cement, granite, goldmining, and foundry-dust fields. Clinical, pathological, social, insurance, and legal aspects of silicosis are also discussed.

The results of the symposium method are here represented at their best. W. H. O.

Medical Education in the United States, 1934–1939. By H. G. Weiskotten, M.D., dean, Syracuse University College of Medicine; Alphonse M. Schwitalla, S.J., Ph. D., dean, St Louis University School of Medicine; William D. Cutter, M. D., secretary, Council on Medical Education and Hospitals of the American Medical Association; and Hamilton H. Anderson, M.D., member of the staff, Council on Medical Education and Hospitals of the American Medical Association. Paper. Pp. 259. Chicago: American Medical Association, 1940.

This volume is a report on medical education in the United States which has been made by a special committee acting under the Council of Medical Education and Hospitals of the American Medical Association. It is impossible to review such a report in the usual way for it is entirely factual. In the pages may be found an answer to almost any possible question concerning medicine in Canada and the United States. Of particular value are the data giving number of students and faculty for each school, qualifications of teachers, admission requirements, and details of financial and educational administration. Of special interest are the chapters having to do with the various departments of instruction. From these may be learned exactly what both the best and the average schools are giving to each preclinical and clinical department in the

(Continued on page 329)

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way of physical facilities, financial support, personnel and educational program. The committee making this report has not tried to influence medical education along any one line. Its clear and comprehensive analysis, however, will lead to much that is good. W. J. M.

Preclinical Medicine. By Malford W. Thewlis, M.D., attending specialist, general medicine, United States Public Health Hospitals, New York City; special consultant, Rhode Island Department of Public Health; associate editor, Medical Times (New York). Cloth. Price, $3. Pp. 223, illustrated. Baltimore: Williams and Wilkins Company, 1939.

Preclinical medicine, as the author conceives it, is that branch of medicine which would ascertain disease conditions which are *likely* to occur, such as peptic ulcer, osteoarthritis and the degenerative diseases. He believes that discovery of the preclinical states should involve the detection of disease tendencies through the study of *stigmas, susceptibilities, probabilities* and *possibilities* of future disease. The general practitioner is designated as being "especially privileged to make these comprehensive diagnoses."

The simplest of the three suggested schemes outlines procedures which are estimated to consume at least three hours, and even this assumes that a detailed history has already been partially obtained, increasing the time per patient to approximately three and a half hours. The "Short Form Study" is summarized as follows:

8:30 a. m. Blood pressure estimation
- Basal metabolism test
- Vital capacity measurements
- Complete urine study and test for occult blood in stools
- Blood chemistry

9:30 a. m. Physical examination
- Roentgenograms if necessary

10:30 a. m. Medical history completed
- Fluoroscopic examination of chest and heart
- Blood taken for:
  - a. Morphology
  - b. Chemistry
  - c. Serology
- Analysis of diet
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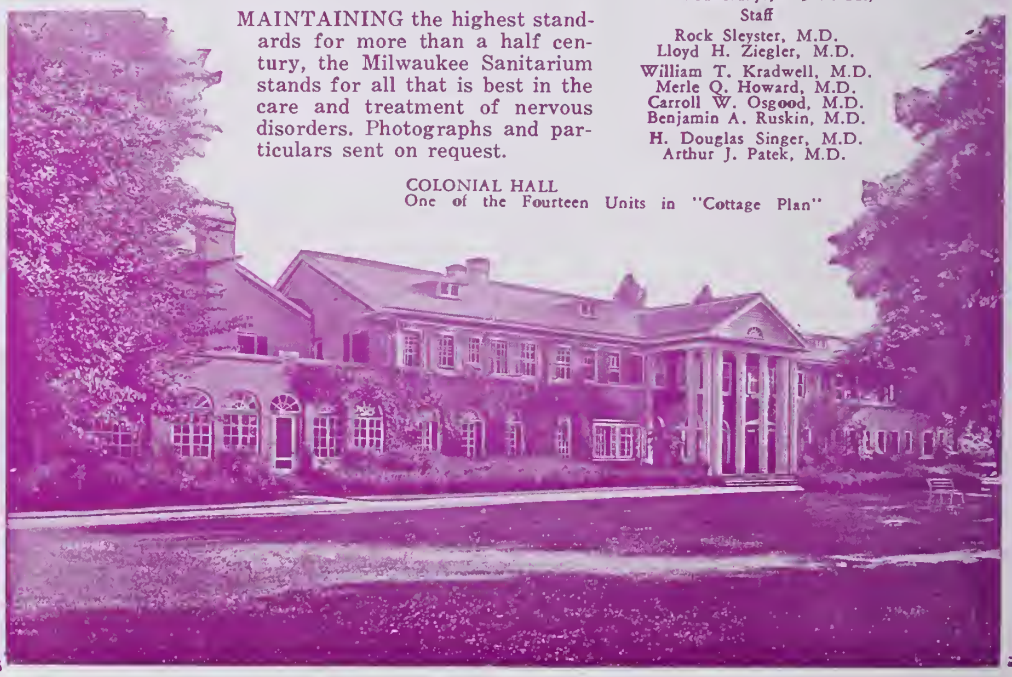

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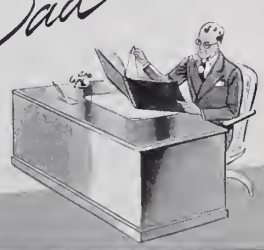

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The chemical, physical, and biological properties of vitamin K have been well established (1, 2, 3, 4). Besides vitamins K_1 and K_2—isolated from natural materials—an homologous series of synthetic compounds has been found to possess antihemorrhagic properties. As the vitamin K unit, the antihemorrhagic activity of 1.0 microgram of pure 2-methyl-1, 4-napthoquinone has been suggested; however, further research seems necessary before final selection of the vitamin K unit is made (4).

Clinical investigations have also established the importance of vitamin K in the clotting of human blood (3, 4). It has been demonstrated that avitaminosis K results in a prothrombin deficiency, with resultant prolonged blood clotting time. Although hypoprothrombinemia can frequently be attributed to inadequate intestinal absorption of vitamin K or to hepatic injury, other causative factors are also recognized; important among these is a deficiency of vitamin K in the diet.

The distribution of vitamin K in foods also has been studied. It has been found that vitamin K activity appears to be concentrated in the photosynthetic portion of the plant (3). Research during the next several years should add greatly to our knowledge of the extent to which this factor occurs in common American foods.

Discovery of vitamin K is another step towards establishment of the complete nutritive requirements of man. Recognition of this new factor, however, suggests that other factors—as yet unknown—will undoubtedly be found essential to man. Consequently, the wisdom of a varied diet to supply the identified, as well as the unidentified, essential nutrients, should be immediately evident. The large number of canned foods, available at all seasons, may well be included in diets designed to promote optimum nutrition.

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REFERENCES

1. 1937. Annual Review of Biochemistry, 6, 364.
2. 1939. Ibid., 8, 428.
3. 1939. J. Am. Med. Assoc., 112, 1457.
4. 1939. Ibid., 113, 2056.

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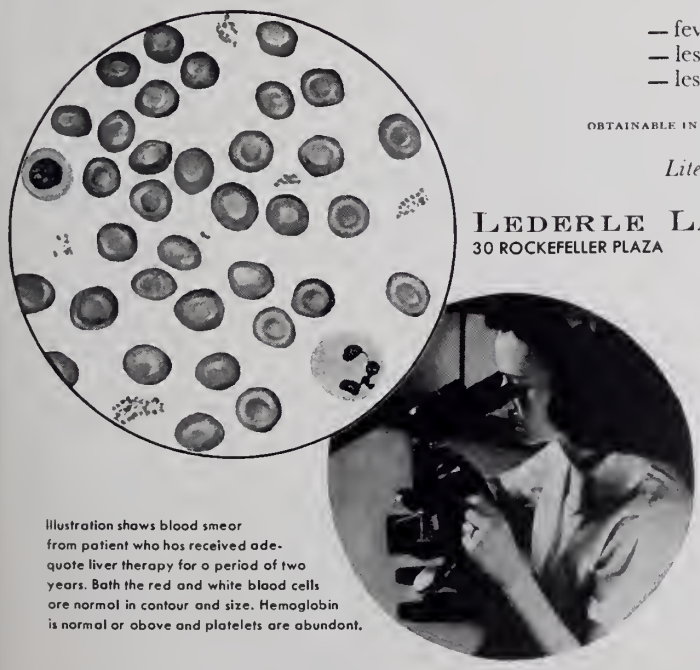

Illustration shows blood smear from patient who has received adequate liver therapy for a period of two years. Both the red and white blood cells are normal in contour and size. Hemoglobin is normal or above and platelets are abundant.

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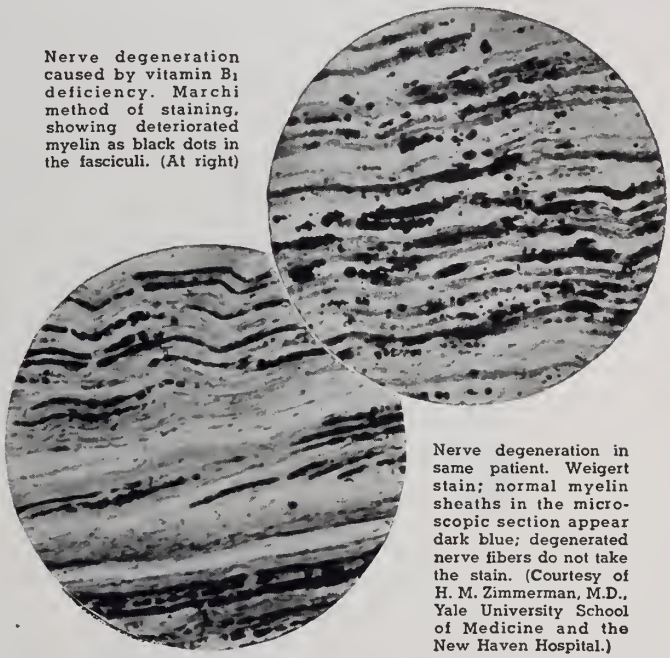
STUDIES IN THE AVITAMINOSES

This page is the fifth of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the April 27 issue of The Journal of the American Medical Association.

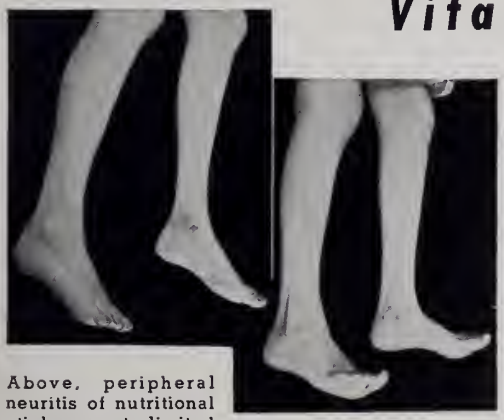
ONE of the specific lesions resulting from thiamin deprivation consists of degenerative changes in the myelin sheaths of nerve fibers. In peripheral nerves, the myelin breaks down into small globules and finally disappears, and the axis-cylinder undergoes atrophy and fragmentation. Degeneration has been described also in the spinal cord, especially in the posterior columns and anterior and posterior nerve roots, and in the posterior spinal ganglions and the anterior horn cells.



Nerve degeneration caused by vitamin B_1 deficiency. Marchi method of staining, showing deteriorated myelin as black dots in the fasciculi. (At right)

Nerve degeneration in same patient. Weigert stain; normal myelin sheaths in the microscopic section appear dark blue; degenerated nerve fibers do not take the stain. (Courtesy of H. M. Zimmerman, M.D., Yale University School of Medicine and the New Haven Hospital.)

The Neurologic Manifestations of Vitamin B_1 Deficiency



Above, peripheral neuritis of nutritional etiology; note limited dorsiflexion. At right, improvement in dorsiflexion after two and one-half weeks of thiamin chloride therapy. (Courtesy of Henry Field, Jr., M.D., University of Michigan.)

THE early manifestations of vitamin B_1 deficiency affecting peripheral nerves are pain and burning along the involved sensory neurons and impairment of motor nerve function. If the deficiency remains uncorrected, fragmentation of the axis-cylinders of motor nerves follows, leading to further loss of function and atrophy of the innervated muscles. Administration of thiamin chloride over a prolonged period slowly produces regeneration of the involved neurons. If complete degeneration of cells and axis-cylinders in the central nervous system has occurred, regeneration cannot take place.

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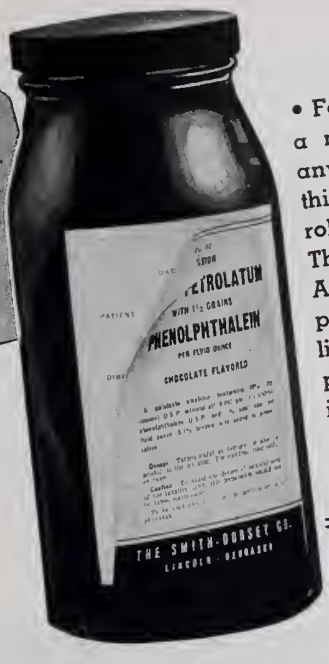

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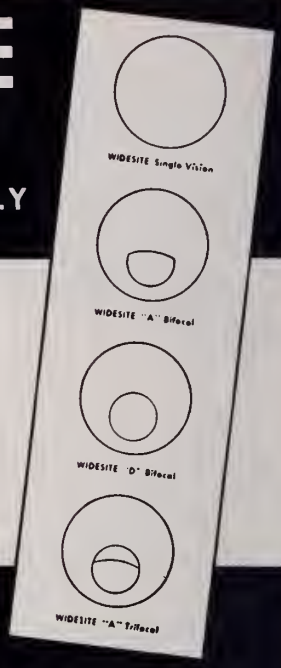

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THE WISCONSIN MEDICAL JOURNAL

VOLUME XXXIX, NO. 5 Copyright, 1940, by The State Medical Society of Wisconsin MAY, 1940

An Adequate Dietary in Later Life*

By E. L. TUOHY, M. D.
Duluth, Minn.

We are in the midst of a great furor over vitamins. The researches of biochemists in vitamin B alone have been so productive and stimulating that even specific crystallization and synthesis have been as newsworthy as war mongering.

I shall touch but sketchily in this paper on the specific features of food adjuvants or protectants, so much discussed presently in lay and scientific journals; rather I propose to discuss the broader aspects of nutrition. I choose to do this, not so much to antidote the so-called vitamin craze, as to capitalize upon an obvious by-product of this remarkable exploitation of dietary deficiencies, namely, a nutrition-conscious public. It is a proper time to direct attention to "the kitchen, the garden, the fields and the grocery," in contrast to the saloon, the beauty parlor and the drug store.

I CHOOSE to discuss the nutrition of older people for three reasons:

(1) I wish to contrast the dietary neglect often accorded the aged to the surfeiting of the young. Fewer children are being born; more are surviving. When pediatricians start infants with a proper dietary (often augmented with vitamins A and D), and when full prevention of contagion and preventable disease is practiced, an amazing hardihood is attained. Press accounts of lost children come to mind. Whether lost in a mosquito-infested jungle, a frigid northern swamp or sparsely covered foot-hills, the young hopefuls, when found within a few days, need only a feeding and a tubbing for rehabilitation. The Indians well knew this fact about children; they also knew how to dispose of the aged by simple neglect and exposure.

(2) I wish to call attention to the need for cultivating proper eating habits and sane attitudes toward food. The vigor passed on from healthy childhood unfettered by preventable disease carries through to the middle decades. In this period of life there is a large field for work among those who over-indulge in food and thus cultivate obsesity, as well as among those who—through fads and fashion—invite undernutrition.

(3) I want to emphasize the fact that the nutrition of elderly people deserves as much attention as that of infants and children. The purpose, of course, is not for growth and development, or for building up immunity to disease, but to promote efficiency and capacity.

Extension of Life Span

Irving Fisher has spoken of "a breadth of life, as well as length" and reminded "there is no area in a straight line." The following paragraphs deal with the "straight line."

Tables 1, 2, 3 and 4 were excerpted from an analysis by Horwood.[1] Table 1 shows the mortality regression in the first thirty-five years of this century. The diseases preventable by mass public health action are decisively on the wane; those secondary to contagion and infection, such as nephritis, reflect the same decline.

* From the department of internal medicine, the Duluth Clinic. Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, September, 1939.

TABLE 1.—*Regression in Mortality* (1900, 1935) from Several Prominent Causes of Death*

Cause of death	Deaths in 1935: Actual	Expected on basis of mortality in 1900	Lives saved in 1935 by improvement in mortality since 1900
All Causes	1,207,359	1,975,761	768,402
Tuberculosis	51,269	224,384	173,115
Influenza and pneumonia	110,191	232,187	121,996
Diarrhea and enteritis	17,018	125,448	108,430
Measles	3,435	12,590	9,155
Scarlet fever	2,646	9,336	6,690
Whooping cough	3,673	10,715	7,042
Diphtheria	3,428	39,486	36,058
Typhoid	2,386	35,652	33,266
Nephritis	89,240	115,239	25,999
Cerebral accident	85,732	102,535	16,803
Puerperal state	10,018	14,504	4,486

* For white population of United States.

In contrast, Table 2 shows the much discussed entities, in which the debit of increased mortalities reflects the moving up of certain major death causes, occurring chiefly among older people.

TABLE 2.—*Increase of Mortality* (1900, 1935) from Several Prominent Causes of Death*

Cause of death	Deaths in 1935: Actual	Expected on basis of mortality in 1900	Lives lost in 1935 by increase in mortality since 1900
Organic heart disease	212,167	153,584	58,583
Cancer	129,124	86,103	43,021
Diabetes	26,606	14,301	12,305
External causes (excluding suicides)	94,851	84,688	10,163

* For white population of United States.

Table 3 shows the increase in life expectancy from 1901 to 1936. Statistics on life expectancy in Queen Elizabeth's time, and even in the time of our War of the States, were largely approximations, but twenty to thirty-five years are often quoted.

TABLE 3.—*Expectation of Life at Birth Among Total Persons (White and Colored) and Among White Persons by Sex for the U. S. from 1901 to 1936*

Year	Expectation of life at birth in years: Total persons	White males	White females
1936[1]	60.81	60.18	64.36
1935[1]	61.37	60.72	64.72
1934[1]	60.79	60.24	64.18
1933[1]	61.26	60.86	64.40
1932[2]	61.07	60.69	64.38
1931[2]	60.26	59.88	63.56
1929–1931	59.57[5]	59.31[6]	62.83[6]
1919–1920[3]	-----	55.33	57.52
1910[4]	51.49	50.23	53.62
1901[4]	49.24	48.23	51.08

[1] Total United States.
[2] United States, excluding Texas.
[3] Aggregate of 27 states; not computed for total persons.]
[4] Original death registration states.
[5] This figure relates to 1930 only for the United States, excluding Texas.
[6] United States, excluding Texas and South Dakota.

Table 4 lists in order of their frequency the major causes of death in the United States. It emphasizes the fact that the conditions resulting in death to the greatest number are due to aging of the body and nonpreventable organic defects.

TABLE 4.—*Death Rates Per 100,000 of the Population in the U. S. in 1933 by Specific Cause, Arranged in Order of Numerical Importance*

Cause of death	Death rate per 100,000 population
Diseases of the heart	228.0
Cancer and other malignant tumors	102.2
Influenza and pneumonia*	95.6
Nephritis and other kidney diseases	85.7
Cerebral hemorrhage	84.0
Tuberculosis, all forms	59.5
Diseases of early infancy and congenital malformations	50.6
Automobile accidents	24.7
Diabetea mellitus	21.3
Diarrhea and enteritis	17.2
Arteriosclerosis	16.8
Suicide	15.9

* If the new chemotherapy for pneumonia proves as worthy as it promises, this disease may in the near future become less lethal than in the past. In this manner, it may join tuberculosis in transferring much of its mortality to the ever-increasing list of degenerative diseases.

A greater appreciation of the striking shift in age groups and their percentages may be gained from Table 5, taken from Christian's timely article on the subject of limitations in preventive medicine.[2]

TABLE 5.—*Advance in Life Tenure from 1800 to 1933, Chiefly by the Saving of the Young*

Year	Life Expectancy No. of years
1800	25–35
1815	38.7
1900	49
1933	61.2

1901	¼	of	population	died	in	the	first	24	years	of life.
1933	¼	"	"	"	"	"	"	52	"	" "
1901	½	"	"	"	"	"	"	58	"	" "
1933	½	"	"	"	"	"	"	68	"	" "
1901	¾	"	"	"	"	"	"	74	"	" "
1933	¾	"	"	"	"	"	"	78	"	" "

Problems Growing Out of Extension of Life Span

Christian[2] bases an appeal for physicians to become interested in geriatrics upon the obvious numbers of elderly people that now and in the future will make up our population. He points out that, despite the large part played by general hospitals in present day practice, patients with preventable diseases are few in number.

It is clear that longevity has been attained, not by improving man as a unit, but by the mass application of scientific methods

along many fronts and by general improvement in standards of living. The average older person surviving today may have deteriorated through withholding the savage rules of natural selection in terms of the physically unfit. Anthropologist "Hooton of Harvard" has backed up this theme with some of our very best current literature and humor.

Life extension has brought with it complex social responsibilities, well illustrated by our Townsend clubs and security legislation. The struggle to maintain living standards shows up our economic and political weaknesses. Science leads but economics stumbles. Our profession suffers dislocation and invites misunderstanding. The situation gives an opportunity for a man like Sigerist of Johns Hopkins[3] to portray his concept of our delinquencies to lay readers. Such criticisms, however, should prove less nettlesome than stimulating. If one of our main jobs is, as Christian puts it, "to make more comfortable the progress of non-preventable disease," then it is incumbent upon us to adapt ourselves to changing conditions and find out how we may do it. *One excellent field, I believe, is to build up a basis for adequate eating, other than the Epicurean rewards and pleasures of the table.*

Divertive Comment on Problems in Life Extension

A brief diversion may not be out of place here. Present day life extension is not due entirely to preventing disease or even to limiting of wars. Improved standards of living, as previously stated herein, have played a part. A book emphasizing this fact has recently been published, "Hunger and History" by Prentice.[4] This challenging title was chosen by none other than the son-in-law of the late John D. Rockefeller. He has conducted an experimental farm at Mount Hope, near Williamstown, Massachusetts. His experiments have been designed to increase the productivity of the soil and of his live stock. Through breeding and proper—not increased—feeding, his hens have increased their annual productivity from 160 to 220 eggs per bird and the milk output of his cows has been increased from 8,000 to 12,000 pounds per cow.

Prentice has sought out evidence on how people lived in the Middle Ages, and evidence on the rigors faced by Stone Age man. His historical researches show that in England, between 1201 and 1600, there was an average of seven famines per century; that, due to faulty harnessing, three or more oxen were required to pull a small plow; that ancient "feasts" would make a cheap cafeteria look like a gourmet's paradise. He mentions a recipe for bread including ground bark, acorns and sawdust, and a suggestion that newborn kittens were good substitutes for crab. He points out that it was only with the advent of the Industrial Revolution (presently so much condemned) that man, with the aid of lower animals, for the first time in twenty-three centuries had food enough to eat, and that this status was attained because the people had freedom. Freedom meant food. Grimly one sees dramatized in the contemporary world the destruction of food. "Guns before butter."

In connection with the problem of nutrition, present trends in soil conservation and animal husbandry should interest physicians. Wilson[6] has collected some interesting facts and figures on this subject. I quote a few:

> "In the United States . . . we have about twice as many people as cattle; . . . three times as many people as swine; ten times as many people as horses and perhaps six times as many people as dogs . . . For the past ten years income from animals and fowls has averaged about one-half the total farm income of the United States. Last year (1938) animal and poultry income to American farms was almost five billion dollars, or about 55 per cent of the entire agricultural income . . . In Wisconsin, five out of every six farm dollars are now animal dollars."

Wilson estimates that in twenty-five years we may see three-fourths of all American farm income taken from animals and fowls. We may ask, "Why?" *Largely because of failing soils and the fertility and erosion problem.* Tilling the land to grasses, legumes, etc., "sews the soil in place."

As Wilson points out, animal husbandry joins the farm with industry. Grass forages and grains are the livestock grower's raw materials. He takes a bushel of corn and a forkful of hay and by the medium of livestock manufactures it into meat, milk, wool, butter, cheese, horsepower, leather and various other commodities. Wilson says, succinctly, "in all the six years of colossal subsidies to farms and farmers . . . more than 92 per cent of all the billions of dollars in 'pap money' has gone into the pockets of annual crop farmers, the 'harassed' growers of cotton, wheat, tobacco, rice and other annual crops." Recall that among these croppers of tobacco and cotton as definite a food deficiency as pellagra is endemic. This is less a product of climate than of soil; of failure of a people to abandon a one-crop regime, develop an animal husbandry fitted to the locale and absorb instruction as to what foods will fill their minimal needs. Goldberger discovered that red meats cured pellagra long before nicotinic acid became a proven specific for certain symptoms.

Professor Auchter,[6] chief of the Bureau of Plant Industry, United States Department of Agriculture,

has recently discussed the relationship between the quality of foodstuffs produced, the availability of sun and rain, and the character of the soil. Tomatoes, for instance, need a small amount of manganese and when it is not present they lack both perfection and prime nutritive qualities. He states that many so-called plant diseases are really deficiencies akin to those occurring in higher animal forms. Farm animals reflect in their products the nature of their available pabulum and the soils upon which it grew. There is something to be said, therefore, as Auchter states, about the advantages of "June butter," early-cut hay, and proper curing and storing of silage to maintain its vitamin content. Good soils and good husbandmen produce high-grade food products.

Who should be more aware of these qualitative factors than doctors or more willing to recommend these quality products?

The trend of our time is to eliminate elderly people from fixed employment and give them in exchange some sort of security sop. This is certainly all contrary to the scriptural adjuration that man shall eat his bread in the sweat of his brow. Leisure, whether acquired or enforced, is not as easily used as many imply. Henry Ford senses this and tries to get his industrialized employees back to the land, both for part-time employment and subsistence.

The matter of bringing peace and amity between urban industrialists and rural agriculturalists is not a medical problem. *Nevertheless, our health standards, as I have shown, will not be maintained unless domestic peace and tranquility exist.* Perhaps our highly industrialized cities must abandon unduly specialized and cloistered employment, even as our farms are abandoning the one-crop regime and becoming small industrialized food factories. There is a value as realistic as life itself in farm products. Wage earners, in budgeting the rewards of their employment, should think less in terms of vacillating currencies and more in terms of the essentials of food, housing, clothing and cultural development.

Rural freedom is too often sacrificed today for the noise and tinsel of urban apartment building crowding. A decisive dislocation apt to follow concerns tenement-born children. A teacher in a large grade school in Brooklyn found that only a few of her pupils had ever seen a cow!

Political reformers do not hesitate to impute to the Machine Age most of our social afflictions, and to the medical profession the blame if some are poorly or illy fed. A statement comes from Washington that our annual income is about sixty billion dollars. This figures out about $9 per week per person. With all the intangibles classed as national income, that doesn't leave much cash to divide. We seem, nevertheless, to have plenty of goods and food, and we know how to provide increasing amounts.

In summary, then, we come to this situation: Speedy, refrigerated transportation facilities and satisfactory canned, processed and preserved foodstuffs universally distributed, leave only two factors which limit the proper use of food: one is economic insufficiency and the other is disease and bad dietary habits.

Dietary Facts and Deficiencies

Domestic prosperity may well be traced back to a wise agricultural economy based on animal husbandry. Is there any factor involved which in any way violates principles of health? Quite the contrary! Man's digestive tract was not designed for long subsistence in the absence of animal foods and concentrates. It will be a long time before those initiated exchange ham and roast beef for soy beans. A high protein diet, except in a rare disease, such as gout or the last stages of nephritis with azotemia, is seldom harmful. Sufficient protein is necessary for nutritional balance. Its lack upsets gastrointestinal digestion and absorption. While carbohydrate diets spare the badly damaged liver, protein-lack cripples the normal liver, as Goldschmidt, Vars and Ravdin[7] have shown. This is just common sense.

Food faddists and absurd textbook diet lists have long perpetuated dietary fallacies. Observe those who persist over-long with the Sippy type of diet for peptic ulcer. Many of them never had ulcer, but the result is the same whether they had it or not.

The "colitis" fad is fading, but the sad symphony of economic and domestic adversity resounds with the wails of the emotionally perturbed and conflicted. It is something we have all heard so often that the appeal, "Doctor, I wish you would put me on an exact list of foods, telling me exactly what I shall eat, for everything distresses me," summons to our consciousness a problem that neither the scalpel nor the medicine cabinet can solve.

Allergists do find a few complainers, but most of the food alarmists are afraid to eat. Constipation, flatulence, anorexia, fatigue and insomnia set up a train of events and vicious circles that upset the whole economy. It is true that over-eating and injudicious selection invites obesity. Emerson is right when he lectures that life insurance companies frown on the obese, and states "1 per cent mortality per pound is added after the age of thirty-five." But I am thinking not of

that essentially happy crew which holds eating to be one of our greatest indoor sports, but of those lanky, cadaverous, emotional dyspeptics—constipated, fatigued importunates, loving followers of "graham cracker" diets—who take all the advice the obese despise.

A high protein diet is in itself highly protective, especially as to hematopoiesis, and indirectly as to digestion and liver sufficiency. Alsted[8] reports an instance of "exogenous pernicious anemia." A young man, through a complaint of simple constipation, put himself on a very limited nonprotein diet. After many months of discomfort and finally weakness, a simple, normal, adequate protein intake (extrinsic factor), without other therapy, gave the same response as liver extract in instances of intrinsic deficiency and pernicious anemia. The point I wish to emphasize, however, is that his normal quota of free hydrochloric acid, absent at first in his gastric secretion, returned. Hydrochloric acid in normal amounts, with a full-sized tongue suitably moist and coated, connotes an individual who favors and enjoys his victuals. How many people lose their hydrochloric acid, and all it stands for in orderly digestion and hematopoiesis, by staying too long on a very low protein diet? Not a few live comfortably without free hydrochloric acid in the stomach. Nevertheless, they are potentially conditioned for serious inadequacies.

I know of no better way to stress the intricacies of deficiencies of similar nature than to call attention to an article by Rhoads,[9] giving the comparative symptomatology of three definite deficiency diseases: pernicious anemia, sprue and pellagra. The manner in which these overlap and the physiologic breaks selectively responsible furnish us with a schema whereby we may very well surmise the presence and interpret the significance of the selective organ and tissue perversion that betoken vitamin B_2 lack.

In like manner, the teaching of Castle[10] to suspect deficiency disorders where the energy output is great—as in fever, exophthalmic goiter, diabetes, exhaustive effort and inadequate food intake—is a great aid in detecting possible avitaminosis. Many symptoms formerly attributed to toxins of diseases such as typhoid, tuberculosis, chronic dysentery and ulcerative colitis, as well as the ultimate results of alcoholism, have really followed vitamin deficiencies. The few patients with typhoid fever seen today are well supplied with calories and survive without developing complications and without much wasting. The anorexia of convalescence responds more rapidly; mineral and vitamin stores are replenished. Pregnancy, with its physiological load and interference with nutrition, and rheumatic fever, may impose on the heart muscle inadequacies for which thiamin offers specific replacement. But so many current medical journals contain inspiring reports on the treatment of these disorders that further emphasis is unnecessary.

Vitamin Concentrates

Normal elderly people should neither be denied a sufficient dietary nor purposeful work. However, age inevitably invites acute or enduring episodes of illness in which a normal food intake is difficult or impossible. The longer these lapses obtain, the more likely certain vitamin concentrates (particularly the B and C groups) are to become very useful pharmacologic agents. These substances are not long stored in the tissues, such as the nerves and muscles where they are currently used, and the liver with only limited capacity is often depressed. The matter of water solubility is important because in the maintenance of water balance in infection, toxemia, shock, hemorrhage, diabetes, jaundice, fistulous losses and diarrhea, there is a tendency to exhaust these stores or lose them by excretion. It is then difficult either to inaugurate sufficient intake of food or to have it of such content that these stores are replaced with sufficient rapidity.

For these situations the biochemists have provided us with pharmaceutical preparations of extraordinary selectivity. Indeed, the science of pharmacology has had a Renaissance. Vitamin B, for example, now has about ten proven components, of which the anti-beriberi factor is least heat resist-

ant. Four others (thiamin chloride, riboflavin, nicotinic acid and vitamin B_6) have been crystallized and synthesized. These chemical miracles challenge our admiration as well as our ability to find their therapeutic province.

Without decrying the peripatetic and loquacious detail men, I humbly imply that we should get our introduction to these specifics by intensive reading and selective use, rather than by the sprinkling around of pluri-potential and cockeyed combinations of everything and anything that sounds like something. The Council on Pharmacy and Chemistry and the Council on Foods of the American Medical Association, sensing this chaotic tendency, have recently made some wholesome rulings.[11] Simple statements of what thiamin and riboflavin actually do in tissue respiration are still quite obscure to clinicians, who, for the most part, have no contact with actual biochemical experimentation. A recent editorial in the Journal of the American Medical Association[12] represents a worthy attempt to state the essentials in understandable form.

It is apparent that energy releases at relatively low temperature levels within the body emphasize the Warburg ferment, conditioning both of the glucose molecule and the nurtured cell, in order to oxidize the fuel, release its energy, catapult it into and fix it in the cell. Intermediary carriers, adapted to varied molecular structure, arise and are utilized by a process of dehydrogenation through enzymes, co-enzymes and catalysts. Cell pigments, "cytochromes," some at least vitalized by iron in a manner comparable to the combination of iodine and amino acids in building thyroxin, are indispensable. As in most physiological processes, the liver adds its fabulous facilities, both for storage and building up of these energy releases. It is said that phosphorylation of thiamin is a liver function, and the product reduces pyruvic acid to carbon dioxide. Other intricate relationships exist for riboflavin and nicotinic acid.

My purpose, here, however, is not to draw attention to these intricacies which current literature is attempting to elucidate. Rather it is my hope that by developing the broader concepts of nutrition we may better select the instances in which these powerful and expensive preparations may be used as isolated agents, and thus lift from ourselves the criticism, rather richly deserved, that we are the agents of well-intentioned but highly competitive pharmaceutical houses that are presently foisting on the public tons of needless vitamin combinations. A conservative level of use is gradually developing. I have elsewhere[13] dealt more intimately, for example, with the therapeutic use of thiamin chloride in instances of cardiac and gastric atony and dilatation, occurring in the course of diabetes. I have since seen a widely dilated colon (megalocolon), which occurred in the course of alcoholic polyneuritis, return to normal after similar treatment.

Medicine never arrives by one bound to any wide front of application. Rather is there an advance in salients when vantage points are gained and consolidation of forces begins. It is one of the functions of our numerous society meeting programs to assist in this process.

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DISCUSSION

W. C. Sheehan, M. D., Stevens Point: Dr. Tuohy, in his consideration of dietary measures in later life, has given us an insight into some of the historical background and present day economic factors, which have an important and interesting bearing on the problem of adequate diets in adults. He has likewise emphasized the tendency of the layman to stress one aspect of his diet, if he is dietary conscious at all, due to the great and spectacular advances in this one line, namely, vitamins.

We, of the profession, in approaching the dietary problem of assumedly normal adult individuals, must consider the problem as a whole. To give advice we must have a generally available knowledge ourselves as to what factors compose what is termed a well balanced diet, and from what general sources these factors are obtained. I would like to add to the information given by Dr. Tuohy what I can, by way of a discussion of an adequate diet.

The first essential of an adequate diet is sufficient energy food to meet the daily expenditure, with a surplus for growth or to build up an underweight individual. The foods which supply this essential are carbohydrates, fats and proteins. Fats yield more than twice as much heat or energy, weight for weight, as protein and carbohydrates, but a diet composed only of fats as a source of energy would be both unpalatable and unwise, since it is an established fact that fats cannot be used well by the body without the presence of sugar. Carbohydrates are our cheapest form of energy food, and proteins the most expensive. In considering the energy requirements of adults, we must remember the patient's age, since with increasing years the metabolic rate decreases; whether he is a laborer, moderately active or sedentary; whether he is obese, normal or underweight; and also the exercise in which he normally indulges.

The second essential of an adequate diet is protein, which we know is required for cell growth and replacement, as a factor in the production of hormones and other body functions. We know that proteins are composed of amino-acids. A few of these amino-acids are termed "essential," that is, the body is capable of synthesizing from the protein taken in all the different acids except those in this small group. These "essential" amino-acids must, therefore, be supplied in the diet as such. Milk is the best and surest source of protein, and with the inclusion of milk in the daily diet (one pint daily for adults and one quart daily for children) along with the meat, eggs and cheese generally taken, one is on the safe side.

The third essential is minerals. The minerals which we are particularly concerned with supplying in the diet, since these are easily neglected, are calcium and phosphorous. The requirement can easily be met by milk as suggested in the protein requirement. Iron is important, but our needs will be met by including greens, meat and eggs in the diet. We need worry little if at all about sodium and chloride since these occur naturally in foods and we all add salt to our diets. Iodine, essential to the production of thyroxin, is of great importance in the so-called goiter belts, but average needs can be met by the use of iodized salt and the consumption of sea foods. Salmon is cheap and a good source. The other minerals—sulphur, copper, manganese, etc.—will be adequately supplied on a varied diet of fruits, vegetables, eggs and cheese.

The fourth essential is vitamins. Dr. Tuohy has emphasized the rapid advancement being made in this field. In dealing with the average person at the present time, we are not apt to encounter any marked deficiency disease due to a total or nearly total lack of any given vitamin. Under the present circumstances, we concern ourselves with the advantages to be gained by generous amounts of the different vitamins. It is generally known that the feeding of these substances at relatively high levels increases resistance to infection, produces normal growth in children, and aids the general health and well being of the individual.

The fifth essential is water. A minimum of one quart of liquid should be taken daily.

In distributing a given sum of money to include these dietary factors, there are certain estimates which have been made and can be used as a guide.

(1) *One-fifth, more or less, for fruits and vegetables.* Economy may be effected by buying in season, using dried and canned foods at other times, and the use of the cheaper vegetables such as potatoes, carrots, cabbage, etc. Fruits and vegetables are good sources of minerals and vitamins.

(2) *One-fifth or more for milk and cheese.* Cheese is generally cheaper than meat, and can be used as a meat substitute. Besides being a less expensive protein food, it is also a good source of minerals and vitamins. The value of milk has already been stressed.

(3) *One-fifth or less for meats, eggs and fish.* With an adequate milk supply, meat serves mainly as an appetizer, and economy can be affected by purchasing cheaper cuts. Fish is seasonal and the market must be watched when economy is a factor. The food essentials supplied by eggs can be met elsewhere, and although eggs are a good food, their inclusion can be governed by cost.

(4) *One-fifth or more for breads and cereals.* These are our cheapest energy foods and can be used exclusively as such if the diet is rounded out with milk and vegetables.

(5) *One-fifth or less for fats, sugars and other food adjuncts.* This item includes the things we like, but can do without in case of necessity.

We are all more or less dependent upon the customs and habits, which include food, of the com-

munity in which we live. Many of the customs are directly traceable to racial influence. I think physicians practicing in cities see somewhat less of this, but those of us who are in smaller communities see the nationality of the people reflected in many of the dishes they serve at their tables, along with the more typically American dishes. We must use our increased knowledge not to eliminate these special dishes, but to balance them with other foods to supply any lacking essentials.

Another problem confronting us is the fallacy of appetite. This is not applicable to those people who like all types of food, and have a variety at hand. However, if appetite runs to starches and fatty foods, we must induce the individual to make a conscious effort to include those foods which supply vitamins, minerals and adequate protein.

Economic conditions, as Dr. Tuohy has said, are one of the greatest causes for an unbalanced diet. This can be overcome by education and intelligence, without a sacrifice of economy.

Observations on the Use of Sulfapyridine*

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Synopsis of Earlier Effort

In 1938, Whitby[1] described his experimental studies on the effect of sulfapyridine [2-(*p*-aminobenzenesulfonamido) pyridine] on mice with pneumococcic infections. Later in the same year, Evans and Gaisford[2] reported on the effects of the same drug in 100 cases of lobar pneumonia, forty-four of which were identified as pneumococcic in origin. Their results were strikingly favorable; the mortality in the cases in which sulfapyridine was used was 8 per cent, and that in 100 control cases of lobar pneumonia in which the drug was not used was 27 per cent. Other observers,[3, 4, 5, 6] have since confirmed the clinical efficacy of sulfapyridine in the treatment of pneumococcic pneumonia.

Concomitant with the widespread use of this drug in the treatment of pneumonia, there have been scattered reports concerning its toxic effects.[7, 8, 9] The most common toxic manifestations reported in the literature, in the order of their frequency, are (1) gastrointestinal irritation [nausea and vomiting], (2) central nervous system symptoms [vertigo and headache], (3) hemolytic anemia and agranulocytosis, (4) dermatitis and (5) urolithiasis.

Purpose and Character of Present Study

BECAUSE of the reported toxic effects from sulfapyridine therapy, a study was undertaken at the State of Wisconsin General Hospital to evaluate this aspect of the drug. Each patient studied was closely observed clinically for signs and symptoms referable to the gastrointestinal system, the central nervous system and the skin. The possible effect of sulfapyridine on the hematopoietic system was studied by frequent laboratory determinations of (1) the red blood cell count, (2) the hemoglobin content of the blood, (3) the white blood cell and differential count, (4) the blood grouping, (5) the fragility of the red blood cell, and (6) the icterus index. Beside these studies, frequent urine examinations were done, and serum protein determinations were also made. Thirty-six patients receiving sulfapyridine were studied; twenty-four of these had pneumococcic pneumonia, three had pneumonia the causative organism of which could not be determined, and nine had miscellaneous infections.

Plan of therapy.—Sulfapyridine was administered orally to every one of the thirty-six patients reported in this study. In general, each patient received 5 grams of the drug during the first day of treatment and 3 grams on each succeeding day in three divided doses. In all cases, the drug was usually discontinued two to three days after the subsidence of fever and other signs of acute infection. The total amount of the drug given varied widely, the smallest total dose being 6.5 grams in a one-year old child and the largest total dose 84 grams in a patient with Streptococcus viridans endocarditis. The average total amount of the drug given was 21.6 grams. Frequent determinations of the blood sulfapyridine content were made in thirty-three patients, and it was found that the average amount in the blood during therapy was 3.7 mg. per 100 cc. In all these patients, sulfapyridine was the only specific therapeutic agent given; but supportive measures, such as the administration of oxygen, blood transfusion, and the parenteral injection of fluid, were employed when indicated.

Clinical course.—In the twenty-four patients with pneumococcic pneumonia treated

* Study made while Drs. Gundersen and Friedman were serving as assistant residents at the State of Wisconsin General Hospital, Madison.

with sulfapyridine, the duration of illness before the institution of therapy varied between one and nine days, the average duration being 3.7 days. In these twenty-four patients, there was one death. This occurred in a man of 72 years, whose pneumonia had existed for seven days prior to treatment and involved both lobes of the left lung and the lower lobe of the right lung. In this same case, a type 1 pneumococcus bacteriemia was present before the institution of sulfapyridine therapy and this disappeared three days after treatment. This patient died on the fifth day after sulfapyridine therapy had been discontinued of cardiac failure. In the remaining twenty-three patients, there was one case of empyema, one of hepatitis, and two of partial atelectasis. Recovery was made eventually in all four cases. It should be noted that the patient who developed hepatitis gave a history of an attack of catarrhal jaundice in her early childhood and of receiving sulfanilamide for two days prior to the administration of sulfapyridine. In this same case, jaundice became clinically evident on the sixth day of sulfapyridine therapy.

In the three cases of pnuemonia in which the etiological agent could not be determined, there was recovery following sulfapyridine therapy in two and death in the third. This death occurred in a patient who had a widespread bronchopneumonia of ten days' duration before sulfapyridine treatment was begun. Because of nausea and vomiting, the drug was discontinued after 8 grams had been given in thirty-six hours. A postmortem examination was not obtained.

Of the nine patients with miscellaneous infections treated with sulfapyridine, two had subacute endocarditis of Streptococcus viridans etiology. One of these died of her infection despite the administration of 84 grams of sulfapyridine over a thirty-day period. The other was discharged from the hospital as unimproved after 32 grams of sulfapyridine had been given. In the seven remaining patients, there was one case of hemolytic streptococcus pharyngitis; one of hemolytic streptococcus bronchopneumonia; one of type 5 pneumococcus arthritis; one of hemolytic streptococcus pharyngitis with associated erythema nodosum; one of staphylococcus empyema; one of type 19 pneumococcus keratitis; and one of Staphylococcus albus septicemia. All seven patients recovered.

Analysis of Toxic Reactions

1. *Effect on gastrointestinal system.*—Of the thirty-six patients treated with sulfapyridine, sixteen experienced nausea and twelve had associated vomiting, but in only two cases was it necessary to discontinue the administration of the drug because of these symptoms. Aside from nausea and vomiting, no symptoms or signs of gastrointestinal irritation were observed.

2. *Effect on central nervous system.*—There were no symptoms or signs of central nervous system irritation or damage attributable to sulfapyridine in the thirty-six patients treated.

3. *Effect on hematopoietic system.*—In general there was no marked effect on the number of red blood cells or the hemoglobin content in any of the thirty-six patients treated that could be attributed to sulfapyridine, either during or after its administration. Likewise, studies of the fragility of the red blood cells of every patient treated, including the patient who developed hepatitis with jaundice under treatment, were within normal limits.

Likewise, the changes in the number of white blood cells and the changes in the differential count were felt to be consistent with the usual trend observed in the subsidence of any acute infection. In no case was there a leukopenia or granulocytopenia. Study of the differential white blood cell counts showed no important changes other than the tendency of the polymorphonuclear element to decrease with the improvement of the patient under treatment.

4. *Effect on serum protein level and blood grouping.*—There was no significant change in either the total serum protein or in the albumin-globulin partition, but in several individual patients there were small changes in both the total serum protein and the albumin-globulin partition which were not considered attributable to the administration of sulfapyridine.

TABLE 1.—*Results of Sulfapyridine Therapy in 36 Patients*

Disease	Number of patients	Recovered	Died
Pneumococcus pneumonia	24	23	1
Pneumonia (organism not determined)	3	2	1
Miscellaneous conditions	9	8	1

Blood grouping determinations done before, during, and after sulfapyridine therapy showed no change in any of the thirty-six patients studied.

5. *Effect on the skin.*—In one patient suffering with subacute endocarditis due to Streptococcus viridans, a transitory macular rash involving the skin of the face, trunk, and arms was observed on the tenth day of treatment after the administration of 32 grams of sulfapyridine. In this case, the blood sulfapyridine content never rose above 2 mg. per 100 cc., possibly due to the fact that persistent nausea and vomiting occurred upon the administration of the drug. The rash rapidly disappeared with the cessation of sulfapyridine therapy. In the remaining thirty-five cases, no skin eruption of any type was observed.

6. *Effect on urinary system.*—In none of the thirty-six cases were there symptoms or signs suggestive of urolithiasis or any other abnormality of the urinary system. Frequent analyses of the urine of thirty-four of the thirty-six patients showed no indication of any abnormality developing during the administration of sulfapyridine.

Summary

The effects of sulfapyridine administration in a series of thirty-six patients are reported. This series includes twenty-four patients with pneumococcic pneumonia, three patients with a pneumonia the etiology of which was not determined, and nine patients suffering from other miscellaneous infections. Special attention was directed not only to the therapeutic efficacy of the drug but also to any possible toxic effects resulting from its use.

In the twenty-four patients with pneumococcic pneumonias treated, there were twenty-three recoveries and one death. Although this series is obviously small, it is felt that the results obtained are comparable to those obtainable following the use of specific antisera. In the remainder of the cases in which sulfapyridine was used, no definite conclusions can be drawn.

The most common toxic manifestation of the drug appeared to be nausea and vomiting which was minor in its severity in the majority of cases. In one patient, a toxic hepatitis with jaundice occurred which may or may not have been attributable to the sulfapyridine administered. A second patient exhibited a transitory macular rash which promptly disappeared after the cessation of sulfapyridine treatment. Careful clinical and laboratory examination of the thirty-six patients studied failed to demonstrate any toxic effects on the central nervous system, urinary system, or the hematopoietic system.

TABLE 2.—*Toxic Manifestations in 36 Patients Given Sulfapyridine*

Toxic manifestations	Number of patients
Nausea and vomiting-severe	2
Moderate	14
Central nervous system changes	None
Hematopoietic system changes	None
Serum protein and blood grouping changes	None
Dermatitis medicamentosa	1
Urinary tract changes	None*

* 34 cases studied.

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Persistent Enuresis*

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ENURESIS is a symptom and not a disease. Its common causative factors can be classified anatomically and pathologically as follows:

I. Congenital causes:
   1. Phimosis.
   2. Pin-point meatus.
   3. Stricture of the anterior urethra.
   4. Stricture of the posterior urethra.
   5. Hypertrophy of the verumontanum.
   6. Submucous fibrosis of the vesical outlet.
   7. Spina bifida.
   8. Ectopic ureteral orifices.

II. Congenital causes plus infection:
   1. Vesical disease, i.e., stone, diverticula, infection.
   2. Renal disease.

III. Infectious causes.

Case Reports

We are presenting the following case reports because they illustrate common faults in the treatment of enuresis; namely, failure to see that a thorough physical examination is made and to realize that many children can be cured of the condition if subjected to a urological investigation. All the patients in the cases here reported had been treated for years as functional or habit bed-wetters, either by their private physicians or as clinic patients.

Case 1. *Enuresis as a symptom of submucous fibrosis of the vesical outlet (Class 1:6, above).*—W. S., a boy aged 11 years, entered the hospital, October 10, 1938, with the complaint of bed-wetting. He was referred to the urological department for examination where it was found that no urinary difficulties were ever noted before July, 1938. Since that time he had had difficulty in starting the stream, which was of a very weak dribbling nature, and paradoxical incontinence, wetting his clothes in the day time and his bed at night. This enuresis occurred two and three times each night. Other history of the past was negative.

Physical examination revealed a fairly well developed, but somewhat undernourished, white male who was febrile and drowsy. On admittance to the hospital his temperature was 103.2 F.; the pulse was 112; the respirations were 24. The predominant physical finding on examination was a globular mass in the lower abdomen extending to one finger below the umbilicus. On rectal examination a fluctuant mass was felt. Five hundred cc. of residual urine were obtained by a catheter which was anchored in place. The patient's temperature was septic in type.

An examination of the blood showed it to contain 12.5 gm. of hemoglobin and 16,400 white blood cells. Blood chemistry studies were done. The nonprotein nitrogen was 38.7,* creatinine nitrogen 1.7, the urea nitrogen 10.7, and the sugar 107.5. The urine was alkaline, clear yellow, had a specific gravity of 1.016, and contained no albumin or sugar. Microscopic examination of it showed 30 pus cells per high power field. Staphylococci and short-chained streptococci were demonstrated on stain and culture. X-ray examination of the spine was normal.

Cystoscopic examination revealed the following: On passing a number 16 French cystoscope a characteristic forward jump was felt as the instrument passed through the internal orifice. A collar-like band of obstructing tissue at the vesical outlet was seen. The ureteral orifices were in normal position and functioning. The bladder mucosa was normal and glistening in appearance.

Excretory urograms were taken on October 14, 1938. These revealed first degree hydronephrosis bilaterally. (Fig. 1.)

Because of the small diameter of the urethra, an electro-resection of the vesical neck was performed through a suprapubic cystotomy under ether anesthesia. A section of tissue taken from an area corresponding to the space between 5 and 7 o'clock on a clock-face was removed from the vesical neck; it proved to be dense fibrous connective tissue on microscopic examination. The temperature remained septic in type for a few days following operation. On November 15, 1938, twenty-five days postoperatively, the suprapubic wound was healed. Two days later there was no residual urine. Excretory urograms were made on November 26, 1938; this was forty-seven days after the patient's entrance to the hospital. These showed a normal upper urinary tract. (Fig. 2.) The patient left the hospital December 16, 1938, without complaint. He was able to urinate freely with a good stream and had no residual urine. Urinalyses at discharge showed three to four pus cells per high power field.

Another series of excretory urograms, made October 3, 1939, showed a normal upper urinary tract. No residual urine was obtained at this time.

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* Blood chemistry values given throughout this paper in milligrams per cent.

Case 2. *Enuresis as a symptom of hypertrophy of the verumontanum (Class I:5, page 363).*—W. T., a white boy, aged 7 years, entered the hospital November 11, 1938, with the diagnosis of abdominal mass, made in the out-patient clinic where the patient had been admitted for a tonsillectomy. Because of a history of hematuria, he was referred to the urologic service for examination. The mother stated there were no specific complaints, but that the child had never been well. He had been a bed-wetter since birth. This bed-wetting occurred three and four times each night and persisted in spite of treatment. He was taken to a hospital for this condition at the age of 17 months and again at the age of 3 years; on the first of these admittances he was circumcised. In the last eighteen months he had had four attacks of gross hematuria, which was terminal in nature. It would be present for three or four days and then disappear for three or four months. The past history was otherwise negative, except for the occurrence of measles and whooping cough.

Physical examination was negative except for a mass which extended above the symphysis to the umbilicus. On catheterization, 500 cc. of cloudy residual urine were obtained.

Examination of the blood showed that the hemoglobin was 10.5 gm., the red cell count 3,290,000, and the white cell count 11,850. Blood chemistry studies showed the nonprotein nitrogen to be 132.9, the creatinine nitrogen 2.8, the urea nitrogen 56.0, the sugar 71.4, CO_2 combining power 29.6 volumes per cent. The urine was cloudy, alkaline, yellow and tested 4 plus for albumin. It contained a few red blood cells and was loaded with pus. Culture of the urinary sediment was positive for colon bacilli. No excretion of dye (skiodan) was noted in a series of excretory urograms. In an intravenous phenolsulfonaphthalein test, 5 per cent of the dye was excreted in two hours. Cystographic examination with skiodan revealed a bilateral hydro-ureter and hydronephrosis. (Fig. 3.)

Cystoscopic examination was performed. A number 16 French cystoscope was passed easily. There was a tumor lying in the internal vesical neck (verumontanum), which evidently was obstructing the out-flow of urine. Both ureteral orifices were patulous and nonfunctioning. The bladder mucosa was like that in chronic cystitis.

The bladder was drained by means of an inlying catheter and there was a resultant fall of nonprotein nitrogen of the blood from 132.0 to 41.9 and of creatinine nitrogen from 2.8 to 1.6. A suprapubic cystostomy was performed for drainage. The patient recovered from the operation and was able to be up and about in a wheel chair. The suprapubic catheter continually drained a cloudy urine, however, and on January 3, 1939, the patient became uremic. Blood chemistry studies on this date showed the nonprotein nitrogen to be 105.4, the urea nitrogen 78.2 and the creatinine nitrogen 3.4. The patient suffered a convulsion the same day and expired.

Fig. 1. Excretory urogram in case 1 revealing first degree hydronephrosis.

Postmortem examination was limited to the urinary tract. The kidneys were typical of chronic obstructive pyelonephritis. The right kidney measured 9x3x1.5 cm. There were large cystic cavitations which had their source of dilatation at the calyces. The parenchyma measured only 6 mm. The pelvis contained granular areas. The left kidney was very much the same but measured 5 cm. in length. The parenchyma was 3 mm. in thickness. Both ureters were tortuous and dilated. Their length when stretched was 24 cm.; the width was 2 cm. The urinary bladder was severely congested and granular in appearance.

In the prostatic urethra, there was a small tumor measuring 4x4 mm. Microscopic section of this tumor, the verumontanum, showed it to contain a considerable increase of fibrous and muscular tissue. The ducts of it emptied onto the surface of the urethra without distortion of the epithelium. Microscopic study of the kidneys revealed chronic pyelonephritis.

Case 3. *Enuresis due to atony of the ureterovesical sphincter causing an infected hydro-ureter and hydronephrosis, with spina bifida occulta (Classes I:7 and II:2, p. 363).*—S. B., a 6 year old white girl, entered the hospital on November 30, 1938, with the complaint of bed-wetting. She had been a bed-wetter since birth. About November 1, 1938, she began to

have colicky pains in the left back, which were associated with chills and fever. The patient was brought to the dispensary to determine the cause of the pyuria and the enuresis noted by her private physician. Her past history was negative.

Physical examination revealed a fairly well developed and well nourished white female not apparently ill. Findings were essentially negative except that she had a septic type of fever.

Laboratory examination showed the blood count and blood chemistry to be within normal limits. The urine was alkaline, and it contained 30 pus cells and an occasional red cell per high power field. Short-chained streptococci were obtained on culture of the urinary sediment. Cystograms revealed a slight funneling of the vesical neck with a reflux of dye on the left and a left hydro-ureter and hydronephrosis. (Fig. 4.) An excretory urogram series showed the right side to be normal. No dye was excreted from the left. Roentgen studies of the spine showed an occult spina bifida of the first sacral segment.

A cystoscopic examination was performed. A number 16 French cystoscope passed easily, releasing about 30 cc. of semi-cloudy urine. The vesical neck was funnel shaped. The bladder mucosa was

Right Left

Fig. 2. Postoperative excretory urogram in case 1 demonstrating the return to normal of the hydronephrosis seen in fig. 1.

Right Left

Fig. 3. Cystogram in case 2 showing the bilateral reflux of dye through patulous ureteral orifices into greatly dilated, tortuous ureters and hydronephrotic kidneys.

fairly normal and glistening in appearance, except for the trigone, where a low grade trigonitis was noted. Both ureteral orifices were in normal position and the right was functioning normally. The left was nonfunctioning and patulous.

On December 27, 1938, a left nephrectomy was performed for "infected nonfunctioning hydronephrosis." The microscopic examination of the surgical specimen showed a marked diffuse, inflammatory infiltration of the parenchyma and advanced hyalinization of the glomeruli.

The patient was discharged from the hospital on January 5, 1939. Her temperature was normal. She had no enuresis.

Case 4. *Incontinence due to ectopic right ureter emptying into the vagina (Class I:8, p. 363).*—V. H., an 11 year old white girl, entered the hospital June 15, 1938, with the complaint of constant dribbling of urine. This was not associated with urination; she was urinating normally but there was a constant dribbling of urine from the vagina. She had been treated since birth as a bed-wetter. The physical examination was essentially negative.

The blood count was within normal limits. The bladder urine showed albumin 1 plus, and contained

ten pus cells and five to six red cells per high power field.

A cystoscopic examination was performed. The urethra was dilated and a number 22 French cystoscope was passed easily. The bladder mucosa was found to be normal and glistening in appearance. Both of the ureteral orifices were normal in position and functioning. These were catheterized full length without obstruction. Retrograde pyelograms and excretory urograms were made revealing a double kidney pelvis on the right. The upper pelvis was drained by an aberrant ureter which emptied into the vaginal vault. (Fig. 5.) The ectopic ureteral orifice was located in the vagina and a catheter passed to the upper pelvis. The urine from this side was badly infected. The left kidney specimen contained only two or three pus cells and no organisms.

On June 17, 1938, an operation was performed. Through a right posterior lateral lumbar incision the kidney was delivered. The upper aberrant ureter was found to be about 2 cm. in diameter; the lower ureter was normal in size. Because the blood supply of the kidney entered the upper pole, heminephrectomy could not be performed. Nephrectomy was done. The patient made an uneventful recovery and was discharged from the hospital on June 29, 1938, with no urinary complaint.

Left Right

Fig. 4. Cystogram in case 3 which demonstrates the funneling of the bladder neck and a reflux of dye on the left into a left hydro-ureter and hydronephrosis.

Discussion

Obstructing lesions of the urethra and vesical neck all produce much the same pathologic changes. Once obstruction has developed the changes which follow are due to back pressure. There is an early compensatory hypertrophy of the musculature producing trabeculation and cellule formation in the bladder. Diverticula are not uncommon. A residual urine develops which becomes infected. It is important to note that infection usually follows an upper respiratory infection, diarrhea, or an acute exanthemata.

When there is an obstructing lesion of the vesical neck, such as submucous fibrosis, there is hypertrophy of the trigonal muscle and vesical end of the ureter with a resultant hydronephrosis. Kretschmer and Hibbs made a study of the vesical end of the ureter in fifteen children with hydronephrosis. Twelve of them were found to have a hypertrophy of the longitudinal layer of the vesical end of the ureter. Three showed fibrous

Left Right

Fig. 5. An excretory urogram in case 4 which shows the ectopic right ureter; the left side is normal.

stricture and an anomalous insertion of the ureter; in one the ureter terminated in the vagina and in two in diverticula.

This hypertrophy can be explained on an anatomical and physiological basis. In 1812 Sir Charles Bell stated that the muscle fibers of the trigone were continuations of the ureters. Young, in 1918, called attention to the importance of the trigone in the act of urinating. In 1920 Wesson published his work regarding the musculature of the trigone and this is generally accepted. He stated that the trigonal muscle is a continuation of the longitudinal muscular coat of the ureter and is superimposed on the muscles of the bladder wall. It is this muscle that pulls open the internal vesical orifice; hence, when obstruction is present, hypertrophy of the trigone and vesical end of the ureter, with resultant hydronephrosis, occurs from overwork in attempting to open the orifice.

Submucous fibrosis of the vesical neck is characterized by sclerotic atresia of the orifice and, in children, is congenital. There have been only twenty-two cases of this condition reported in the last twenty-five years, but a paucity of reports is no indication of the frequency of the condition. The pathologic picture is much the same as its descriptive name. This fibrosis sometimes involves the trigonal muscle as well as the orifice. It may encircle the outlet or just include a segment of it, the portion corresponding roughly with the numbers 5 and 7 on the face of the clock being a common site. Histologically, one finds in this condition dense fibrous connective tissue in the submucosa. This point is well illustrated in case 1, described herein.

Another obstructing lesion is hypertrophy of the verumontanum. Fagerstrom states that Swinburne first called attention to this in 1910. In a study of 4,903 necropsies in infants, Bugbee and Wollstein found twenty-five cases of bilateral hydronephrosis. In 32 per cent of these the obstructing lesion was found to be a hypertrophy of the verumontanum. When urinary difficulties in male children are not due to phimosis or pin-point meatus, valvular obstruction of the posterior urethra should be considered. Hypertrophy of the verumontanum is often associated with this condition. It is the situation of the obstruction and not its size that produces marked changes in the urinary tract. Case 2 demonstrates this fact.

Neurogenic disturbances of bladder function should be considered in dealing with enuretic patients. Spina bifida is one of the most common lesions causing this condition in children, but there are many symptomless cases of spina bifida and spina bifida occulta. Neurogenic dysfunction causes varied effects. Patent ureteral orifices may be seen when the lesion affects the presacral nerve. Incontinence may be due to an involvement of the sphincter or to an overflow of urine. Cystometry is of value in these cases.

A wide assortment of treatment is prescribed for enuresis, ranging from corporal punishment to spinal puncture. One commonly employed measure is tonsillectomy. This, although appearing rather remote, is based on the work of Guy L. Hunner, who many years ago brought out the idea of nonspecific infection of the urethra and trigone in girls, due to a focus of infection. He advocated removal of the focus and reported this would result in a spontaneous disappearance of the vesical lesion. In this connection, it is well to remember that cystitis is a secondary infection. Vesical conditions producing enuresis must include stone, foreign body, diverticulum and fistula.

Renal infection may be the source of a cystitis resulting in enuresis due to bladder irritability. This infection may be of a specific nature as in tuberculosis, or of a nonspecific nature as in colon bacillus, streptococcus or staphylococcus infections. An eradication of the infection surgically or by the administration of proper medication will result in a cure of the condition.

Ectopic ureteral openings are quite rare in occurrence. There are a variety of situations in which they may be placed. The abnormally implanted ureter is commonly a supernumerary one. Cabot states that in 75 per cent of 118 published cases collected by Gruber the ectopic ureter belonged to the upper half of a double kidney. Of the seventeen cases reported by Campbell, there was reduplication of the aberrant ureter in eleven cases and partial reduplication in one case. Patients who have ectopic ureteral orifices

present themselves with a clinical picture of either urinary disturbance or urinary infection. Children with this condition usually are treated for enuresis and adults for incontinence.

Most cases of enuresis have a psychogenic basis, but when the condition is persistent the patient should be given the benefit of a thorough examination. Symptoms produced by obstructing lesions are those referable to obstruction of the vesical neck, sepsis and renal impairment. In the study of persistent enuresis, an investigation for residual urine, a careful analysis of the catheterized specimen, and a series of excretory urograms are great aids in diagnosis.

Conclusion

Many cases of so-called enuresis have urinary tract disease as their bases; these can be detected and treated if a thorough examination is carried out.

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Thrombophlebitis in Obstetrics

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Racine

OPINIONS differ profoundly as to the etiology of thrombophlebitis. One concludes from a review of the literature that this phenomenon is due to a combination of factors.

Tissue trauma and sepsis are acknowledged as the two primary factors. The frequency of their co-existence in the condition make it practically impossible to determine which exceeds the other in importance. Slowing down of the blood stream (stasis), which is always present in thrombophlebitis has been accepted as the most formidable predisposing cause. It has also been observed that in the presence of tissue trauma, stasis and sepsis, there is a disturbed interchange between the vessel walls and the plasma of the blood, and this is believed to increase susceptibility to thrombophlebitis.

At the South Side Lying-in Hospital, Stockholm, Sweden, between the years 1912 and 1927, according to a report by Nettelblad,[1] there were 434 cases of thrombosis and embolism in 50,000 deliveries, an incidence of 0.8 per cent. The incidence in this series was highest following difficult labor, especially after hemorrhage and manual removal of the placenta.

Westmann,[2] Berlin, stated that the incidence of thrombophlebitis during pregnancy is 0.1 per cent and during the puerperium 5 per cent; that in puerperal women primary thrombosis of the femoral vein occurs in 0.2 per cent and in puerperal fever in 0.5 per cent.

The formation of thrombi in the mouths of vessels at the denuded site of the uterus is a normal phenomenon. The thrombi form, the vessels retract and contract, and bleeding stops. Some of these become infected and some do not; the former constitute a pathologic condition, the latter a normal physiologic phenomenon. For the sake of clarity and brevity this discussion will be limited to infected thrombi occurring after obstetrical procedures. This subject matter in its

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most restricted sense allows the following broad subdivisions:

1. Thrombophlebitis involving the pelvis partially or completely (pelvic thrombophlebitis).
2. Thrombophlebitis involving *only* the femoral vein (phlegmasia alba dolens) of which there are two types; namely, that involving the deep femoral vein and that involving the superficial veins.
3. Thrombophlebitis of the pelvis with phlegmasia alba dolens.

Any one of these conditions presupposes tissue trauma and the presence of infection in the uterus.

Pelvic Thrombophlebitis

The following are accepted avenues of introducing infection into the uterus:

1. A septic vaginal examination.
2. Too frequent vaginal examination.
3. Retained placental tissue.
4. Undue obstetrical procedures or manipulation.
5. Early rupture of membranes.

The literature and statistics show one is justified in assuming that the uterus contains pathologic organisms if any moderate degree of dilatation exists and if the membranes are ruptured six or more hours. When a cesarean section is contemplated and these two conditions exist, it is well to recall this fact in determining the type of section to be performed.

Usually thrombophlebitis is either an anaerobic or streptococcic infection, and culture for both types of organism is therefore feasible. Bacteria never multiply in the blood stream *per se,* as often mentioned, but only on tissue at the foci of the infection. Therefore, one should select the proper time to take a blood culture, namely, immediately following a chill. Following these procedures gives the greatest percentage of accurate blood cultures.

From a clinical standpoint a cervical infection is a uterine infection. The extending infection may be a *pure* or a *mixed* one. The former is caused by both hemolytic and nonhemolytic streptococci and the latter by staphlococci and Bacillus coli communis. Each type has its characteristics. In the mixed form the uterus is large, boggy, and tender. The lochia is increased in amount and possesses the typical offensive odor of the Bacillus coli communis. The lining of the uterus shows a shaggy out-growth. The invasion of the bacteria into the wall of the uterus, lymphatic channels, and blood stream is early. In the pure type the findings are quite different. The lining of the uterus is practically unchanged. The lochia is odorless; the amount normal or less. The progress of the illness is far more rapid, its severity more fulminating. Both types are accompanied by profound toxemia and secondary anemia. Prolonged convalescence, marked by mild relapses, is usual. The prognosis is good if the activity of either of these two types of infection is limited to the uterine cavity.

However, an acute exacerbation as severe as the original onset, or more severe, predicates the evidence of a pelvic extension, partial or complete, with the subsequent development of parametritis. Pain on one or both sides of the lower abdomen designates this extension. Soon a demonstrable and palpable mass and signs and symptoms of thrombophlebitis, in one or both lower extremities, make their appearance. This parametritis may terminate in a dense cellulitis on one or both sides; hence, the descriptive term "frozen pelvis." This encircling exudate may begin as an abscess, palpable through the rectum in the cul-de-sac, or as a more solid exudate, requiring days or weeks of expectant treatment before it resolves into an abscess. Secondary anemia, leukocytosis, and a shortened sedimentation rate of the red cells are accompanying laboratory findings. Endometritis, pariendometritis, myositis and parametritis complete the clinical picture for pelvic thrombophlebitis, partial or complete.

Although this extending infection may localize, more often, due to the patient's lowered resistance, the overwhelming virulency of the organism or the tardiness of proper attention, these infected thrombi disintegrate, break loose and shower themselves into the general blood stream, causing metastatic pyemia, metastatic bacteriemia or septicemia. These infected thrombi may lodge in any vital center,—the lungs, kidneys, brain, joints, or even the eye, to form new foci for further metastatic involvement.

If a thrombus is of sufficient size and lodges within the lung, sudden death ensues from pulmonary embolus. A small thrombus may lodge within the lung causing a lung infarct and resulting in pleurisy or pneumonia. These two sequelae are often encountered. Emboli in the lung may be sterile or infected. But, if infected and laden with bacteria, the outcome is quite different and the prognosis exceedingly grave.

Phlegmasia Alba Dolens

In thrombophlebitis involving only the femoral vein, the pelvis is entirely free of involvement, whereas, in the thrombophlebitis just described, the pelvis is always involved. When the infection is limited to the femoral vein, the condition is commonly spoken of as phlegmasia alba dolens.

Two varieties will be described: first, thrombosis of the deep vein; and second, thrombosis of the superficial veins. One is always associated with infection; the other is often considered as a thrombus in the femoral or saphenous vein without infection. But this differentiation is still a disputed point. Thromboplebitis of the deep vein is severe; thrombophlebitis of the superficial veins is comparatively mild. Perhaps this is the only clinical difference in the two types. In either type, the onset is between the second and third week; most frequently it occurs on the eighth, ninth, or tenth day postpartum.

Thrombosis of the deep vein.—Thrombosis of the deep vein is usually characterized by severe deep-seated pain in the groin and calf of the leg. The pain progresses in the order mentioned. Of great diagnostic importance is the immensity of the swelling of the thigh and buttock with its rapid progress from above downward, spreading sometimes the entire extent of the extremity. This significant white swelling, which persists for some time or occurs later, is due to lymphatic obstruction. The thrombosed vein may be palpated below Poupart's ligament. The fever is "spikey" in type. The pain may spread to other localities. A chill may precede the pain. In this condition, as in pelvic thrombophlebitis, pyemia is wont to occur.

If repeated chills with marked remission in temperature and a very rapid pulse are the order of things, some pelvic involvement is certain and pyemia is imminent. The swelling then becomes edematous, the pain is accompanied with exquisite tenderness, and the thrombophlebitic vein is definitely demonstrable. At this stage some pelvic involvement complicates phlegmasia alba dolens. The latter term, phlegmasia alba dolens, however, in its strictest sense, implies thrombophlebitis of the femoral vein only.

Thrombosis of the superficial veins.—In thrombosis of the superficial veins, the thought is that an aseptic thrombosis exists; that the thrombosis is a direct extension from a sterile thrombus. Stasis in the traumatized veins, and the quiet recumbent position of the patient postpartum, favor the extension. But most authorities feel that organisms play a role in this type too. Many go so far as to insist that there is some low grade pelvic involvement, the only difference being the degree of severity. It is in this type that much has been written concerning the prophylactic expediency of systematic exercise during pregnancy and puerperium.

This type is more frequent and of a milder nature than thrombosis of the deep vein. There is tenderness about the femoral vein. And there is swelling of the lower extremities, occurring in the reverse way, from the bottom upward. The upper limb is congested and the veins tend to become varicosed. Because of obstruction in the venous and lymphatic vessels and channels, the state of the lower leg is bad and gives the impression of seriously damaged circulation. The temperature is not as high nor as "jagged" as in thrombosis of the deep vein; it usually plies between 100 and 102 F. The pulse is moderately accelerated. The duration of the condition is from three to four weeks, sometimes six weeks. The edema is slight as compared to thrombosis of the deep vein and clears up more rapidly.

Thrombophlebitis of the pelvis with phlegmasia alba dolens is possible and probable in any given case. The two distinct entities may be differentiated. Either may precede the other or, running concurrently,

present such a bizarre clinical picture that one must consider them as a single entity.

Treatment

Salient points in the treatment of either of the two forms of phlegmasia alba dolens, with or without pelvic involvement, are as follows:

Under no circumstance permit any massage.

Institute the best nursing care possible and place the patient in the most pleasant surroundings available.

Provide a good wholesome diet with a high vitamin content.

See that the patient gets plenty of fresh air and sunshine.

Treat the patient as you would one with tuberculosis and remember the thrombophlebitic patient needs all the supportive treatment a tubercular patient requires.

Local treatment includes elevating the affected limb so that the heel is free, the calf of the leg rests on a broad surface, the knee is higher than the pelvis and the leg from the knee-cap to the ankle joint is parallel with the floor. Place a cradle over the properly elevated extremity in its entire length, rigged with electric-light bulbs to give an even, dry, comforting heat and to eliminate even the weight of the bed clothing. Support the foot to prevent drop-foot and apply an ice bag to the groin over the thrombotic area. Change the patient's position with the minimum amount of exertion to minimize the possibility of embolism.

Never permit the patient to get out of bed until the temperature and pulse are normal and all tenderness on deep palpation has been absent for ten days or two weeks. This is very important. It is a good idea to let the patient get up gradually. First one leg may be put over the edge of the bed and then the other leg. Next the patient may sit on the edge of the bed and on the third day in a chair. If there is any elevation in pulse or temperature, or if tenderness is again observed, keep the patient in bed three or four days more. Then allow her to try getting up again, cautiously.

It is important to tell these patients their legs will be swollen one or two and sometimes even three years. It is not uncommon for these extremities never to assume complete normalcy. Always dismiss such patients with elastic stockings for support. Warn them not to massage the extremity until six or eight months after being up and about.

Prontylin may be tried but only when a chemist is on hand who can evaluate the accumulation of the product in the blood. It is questionable whether it is wise to use this drug unless positive cultures warrant it. However, even in case of a negative blood culture, if the clinical picture is desperate enough, one is justified in attempting this new therapeutic measure. The suggested dosage is 60 grains the first day; 30 grains the second day; and 20 grains the third day *if warranted after the amount of the chemical in the blood has been evaluated in the laboratory.*

Transfusions are helpful, but they should be small, varying in amount from 200 to 300 cc.

Conclusions

1. The etiology of thrombophlebitis is still a disputed point. One group attributes it to mechanical and chemical factors; another to a manifestation of infection; a third to a combination of all these factors.

2. For the sake of clarity and brevity the subject matter of this paper was limited to thrombophlebitis following obstetrical procedures and the primary etiologic factors were assumed to be tissue trauma and sepsis.

3. An arbitrary classification with many of the important clinically differentiating points was presented.

4. Therapeutic measures commonly employed were mentioned.

5. Emphasis was placed on the fact that thrombophlebitis should be suspected if, following an obstetrical procedure, the patient has a persistent low-grade fever for which no demonstrable cause can be found.

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Nonsuppurative Disease of the Cornea*

By EDWARD R. RYAN, M. D.
Milwaukee

NONSUPPURATIVE disease of the cornea embraces a multitude of affections, the majority of which are seen rarely and are relatively unimportant. No endeavor will be made to cover all of these diseases, but rather to call attention to those herpetiform eruptions, dendritic keratitis and superficial punctate keratitis, which are seen most frequently and are most frequently overlooked. During the last decade these conditions have been recognized oftener and have become better understood, chiefly because of the more universal use of the slit-lamp.

Dendritic Keratitis

According to the classical description of the disease, dendritic keratitis begins as a group of very fine blisters which eventually coalese, lose their epithelial covering and form a branching ulcer resembling a dendrite, from which it gets its name. I personally have never seen the vesicles and there is a question in my mind that they do occur. Gundersen,[1] in analyzing 221 patients with dendritic keratitis, has had the same experience. It seems odd that the vesicles should all occur and erupt at the same time and do not present themselves in crops or occasionally at a time when we could observe them, for we have all seen progress of the corneal lesion.

The attack comes on suddenly with burning and stinging and the patient frequently believes he has a foreign body in the eye. It is in this stage that the disease is most often overlooked for no foreign body will be found, and unless the cornea is stained and carefully examined with the slit-lamp the minute erosions will be missed. In this particular geographical area dendritic keratitis most frequently follows an attack of grippe or an upper respiratory infection and these latter infections need not be severe but, as a matter of fact, are usually of an insidious nature. Occasionally the disease follows trauma from a foreign body, a tear from a twig or fingernail; it may occur without any apparent antecedent cause.

In all cases there is either an anesthesia of the cornea or a decrease in the corneal sensitivity as compared with the cornea of the good eye. In every case corneal sensitivity should be tested with a wisp of cotton and it is important to remember to test the sensitivity of the entire cornea with vertical and horizontal strokes of the cotton, for more frequently than is generally supposed there will be an island of anesthesia rather than anesthesia of the entire cornea. Hypesthesia of the cornea may exist for a long time after the disease is apparently cured, and in some cases the sensitivity of the cornea never returns to normal. This possibly may be a factor in the numerous recurrences, for once an individual has dendritic keratitis he is greatly predisposed to another attack.

There is always considerable conjunctival congestion and some iritic irritation and it is seemingly paradoxical but characteristic of the disease that a patient should present so much pathologic change with so little complaint. A few patients exhibit cells in the anterior chamber but hypopyon occurs infrequently.

Occasionally the disease is complicated by a rise in intraocular tension and some observers attribute the pain to this rise in tension. Needless to say, the tension should be tested on every visit of the patient to the office. I prefer to test the tension with the fingers rather than with the tonometer for, after all, a fairly accurate idea of the tension can be obtained with the fingers and no added insult is given to the already diseased corneal epithelium.

A serious complication is disciform keratitis. Fortunately, however, this is seen in only a small percentage of cases.

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* Presented before the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

Superficial Punctate Keratitis

The term "superficial punctate keratitis" was first used by Fuchs[2] to describe the disease that begins as fine punctate nodules. These nodules, which usually occupy the center of the cornea and increase in size, lie below Bowman's membrane, never ulcerate and cause considerable visual loss. The term is now used with a great deal more elasticity than formerly and includes all small superficial epithelial erosions, be they punctate, oblong, or irregular.

There is considerable disparity of opinion as to the frequency of this disease. No less an authority than Lloyd[3] reported in 1930 that he had only seen two or three cases over a period of twenty years. At the other extreme we have Rankine[4] who observed 1,598 cases among workers in the rayon industry over a period of two years. Certainly, in this locality, superficial punctate keratitis occurs much more often than the dendritic form and this, being an industrial sector of the country, may be accountable for the more frequent occurrence.

Davidson[5] calls attention to the occupational factor in superficial punctate keratitis and states that it is not a serious condition per se and, as there is seldom perceptible loss of visual acuity, does not present a problem in working men's compensation but does influence the effect of foreign bodies and erosions, their treatment and infections. For those doing a considerable amount of industrial work it is a factor that should be constantly kept in mind.

Photophobia and blurring of vision are usually the only symptoms complained of, and the degree varies with the severity of the corneal involvement. There is always an accompanying acute, subacute, or chronic conjunctivitis and any number of these patients have been treated for weeks for conjunctivitis without the true nature of the disease being suspected. Unless the cornea is stained and examined with the slit-lamp the corneal lesions will not be seen. Hypesthesia of the cornea is a prominent and important symptom and occasionally the disease is complicated by glaucoma although little is mentioned in the literature of this complication. I have recently observed one such case.

The slit-lamp picture, as described by many observers, is strikingly uniform. Vogt[6] describes the lesions as closely-packed, grayish points, commas, or lines, and seen only after staining with fluorescein. This well epitomizes the description of many slit-lamp studies. Davidson[5] prefers mercurochrome for staining because it is less diffusible than fluorescein and provides a better contrast between the lesion and the surrounding area.

Synopsis of Previous Effort in Treatment

That the treatment of these diseases is far from satisfactory is best attested by the numerous therapeutic measures that have been proposed for their treatment. Lloyd[3] believes that in dendritic keratitis the eye should be kept covered until the sensitivity of the cornea returns. He applies pure phenol to the ulcer every other day and uses x-ray therapy for glaucoma. Selinger[7] treated eleven adults with dendritic keratitis with a 2 per cent quinine bisulphate ointment applied to the conjunctival sac two times daily. In every case the subjective symptoms improved immediately and there was no extension of the corneal lesion as evidenced by the fluorescein stain. The lesions healed within three weeks. Kentgens[8] believes the systematic and local use of vitamin A is helpful in herpes, punctate keratitis, and marginal and catarrhal ulcers. In forty-eight patients in whom it was used the average healing time was seven days, while in thirty-eight patients with similar lesions, in whom it was not used, the average healing time was eighteen days.

Gundersen,[1] in dendritic keratitis, uses a strong solution of iodine which contains 7 per cent iodine and 5 per cent potassium iodide in alcoholic solution. This is applied to the entire cornea three or five times or until a deep chestnut brown color is obtained. The iodine is then neutralized with a cocaine solution. The epithelium becomes white, opaque, and necrotic, and after twenty-four hours the smooth glistening Bowman's membrane can be seen outlined by fresh epithelium growing from the periphery. Complete re-epitheliation occurs rapidly.

Law[9] and Gundersen,[10] working independently, both conclude that ultraviolet therapy has little use in the superficial forms of keratitis, and Lloyd[3] believes that the infra-red lamp has a great deal of virtue, holding it next in importance to constant occlusion of the diseased eye. Syrup of iodine, as recommended by Gifford,[11] is composed of five minims each of tincture of iodine and glycerin to ten grains of powdered iodine crystals to which three drops of saturated potassium iodide solution is added. This is applied to the ulcer daily or every other day with a small pointed cotton pledget.

Selinger[12] has used a 2 per cent ointment of quinine bisulphate in two cases of disciform keratitis which had existed six months or longer, and reports marked clearing of the infiltrates within two weeks after the treatment was started.

Cowan[13] prescribes a 1 per cent solution of potassium iodide containing one or two minims of compound solution of iodide U. S. P. to the ounce, for home use, in superficial punctate keratitis. This is instilled into both eyes three times daily and con-

tinued for a long time after the lesions are apparently healed. For office treatment Pregl's solution is employed in the form of conjunctival packs; 0.5 cc. of the fresh solution is used and the pack is allowed to remain in place for ten minutes. The pack is used every four days.

Treatment of Dendritic Keratitis

I prescribe constant occlusion of the diseased eye in dendritic keratitis, continued long after the ulcer has healed and until the sensitivity of the cornea has returned to normal, in all cases. Lloyd[3] considers this the most important therapeutic measure in the treatment of dendritic keratitis. Gundersen[1] states the use of an eye cover was not found to influence the rapidity of corneal healing and was used only when the patient's comfort seemed to require it. This last statement does not seem tenable, for with a cornea that is anesthetic, the winking reflex is reduced and the already diseased epithelium becomes greatly exposed to wind, dust, and foreign particles that may cause additional injury to the epithelium and corneal infection.

Tincture of iodine has been discontinued by me and syrup of iodine as recommended by Gifford[11] is used in its stead, for in my hands the results have been better. I must hasten to admit, however, that I never have had the courage to use the tincture of iodine as extensively as Gundersen[1] recommends. The cornea is anesthetized, the ulcer stained, and with the aid of good illumination and the loupe, the syrup of iodine is applied thoroughly and quite vigorously, with a small, pointed, cotton-tipped applicator, to the ulcer and adjacent epithelium. If proper application has been made, the ulcer and adjacent epithelium will stain a rich golden brown. This procedure is repeated every other day until the ulcer is healed. There will be a varying amount of pain for three or four hours following each application, which can usually be controlled by 15 grains of sodium salicylate.

Atropine is used in all cases and is continued for five or seven days after the ulcer has healed. Cod-liver oil is given if the patient's general condition seems to demand it. Other than that, no vitamin therapy has been used. Five per cent dionine is prescribed for home use.

In two cases of glaucoma observed by me, the tension was nicely controlled by discontinuing the atropine and using an adrenalin pack and hot fomentations. When disciform keratitis occurs, treatment is of little avail.

Treatment of Superficial Punctate Keratitis

Much the same regime is used in the treatment of superficial punctate keratitis as is used in the dendritic form. The diseased eye is kept constantly covered as long as there is decreased corneal sensitivity and this may be some weeks after there has been an absence of corneal lesions.

The conjunctivitis should receive active treatment and before the treatment is instituted a culture of the conjunctival sac should be made. Two per cent silver nitrate is applied to the palpebral conjunctiva after the eye has been anesthetized, and various ointments are prescribed for home use. The choice of ointment depends on what is found in the culture. Zephiran (1:3000) is preferred in the staphylococcic infections and 0.5 per cent silver nitrate in the pneumococcic. It is important to remember that silver nitrate ointment should be freshly prepared, for after a short period precipitation occurs and then the drug becomes more detrimental than useful. In certain types of chronic conjunctivitis 3 per cent ammoniated mercury is the ointment of choice. If there is a meibomitis, the ducts should be massaged and emptied.

Dionine is instilled from the beginning and atropine is used if there is iritic irritation.

One case of glaucoma has been observed, and that in an elderly patient not using atropine. The tension was easily controlled by adrenalin packs and heat.

Too favorable a prognosis should never be given these patients for in too many cases the disease defies all treatment and may continue for many months.

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Comments on Treatment

EDITORS
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and
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The Immediate Treatment of Convulsions in Children

First, protect the child against injury. Second, if there is a fever give a cool pack or sponge or enema to lower the body temperature. Any manifest infection, such as an abscess in the ear or a throat infection, must be treated locally. A hot bath, the standard lay treatment of a convulsion, has no particular value and may be a dangerous procedure. In the excitement of treating a convulsion the bath water is often too hot for safety and severe burns have resulted. An enema is always in order unless the child has just had a stool. The enema should be given first with a normal saline cleansing solution and then with a 50 per cent magnesium sulphate solution. The latter solution should be retained as long as possible.

If the convulsion is a major one and does not appear to be subsiding, or if it has been active for some time, the most effective and practical, and the simplest procedure is anesthetization with chloroform or with vinyl ether. The latter preparation acts more quickly and the patient returns to consciousness as soon as the vinyl ether is discontinued. The anesthesia is not as deep and the drug appears to have few harmful side effects. However, the possible harmful effects of chloroform cannot be considered in the treatment of the much more potentially harmful convulsion. Every general practitioner should carry a small vial of vinyl ether or of chloroform in his bag to treat convulsions. Status convulsivus will be fatal unless it is treated promptly. If neither of these two anesthetic agents is available, the patient should be given magnesium sulphate in saturated solution by mouth or by enema. If a sterile solution is available, a 20 to 50 per cent solution may be given intramuscularly. A 20 per cent solution of magnesium sulphate may be given slowly by vein if the patient can be sufficiently restrained.

Soluble phenobarbital may be given subcutaneously in the treatment of the milder convulsions, but its effect is variable and slow.

If a diagnosis of tetanus has been made, tetanus antitoxin must be administered promptly and then tribromethanol given by rectum.

In spasmophilia or tetany the convulsions are treated with some preparation of calcium. Calcium chloride in 10 per cent aqueous solution may be given by mouth, 45 to 60 grains, by gavage if necessary. This initial dose should be followed with 15 grains every six hours for two weeks or longer. Calcium gluconate in sterile 10 per cent solution may be given intravenously or intramuscularly for the first few doses in 5 to 10 cc. amounts. Viosterol and acid milk are given coincidentally and then continued for long periods.

Blood for examination should be taken before treatment is instituted, whenever possible, and sugar, calcium and phosphorus

(Continued on page 405)

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« « « EDITORIALS » » »

99th ANNIVERSARY MEETING, STATE MEDICAL SOCIETY OF WISCONSIN
September 18, 19 and 20, 1940, Milwaukee

Consultations in Compensation Cases Under Open Panel Agreement

"When consultation is desirable, I shall obtain consent of the insurance company, when possible, prior to calling in consultation, and whether consultation is requested by me, the patient, or the insurance company, every effort will be made to secure a consultant mutually acceptable."

EACH member of the State Medical Society of Wisconsin who has made application for listing on the panel, which is prepared by the State Medical Society and distributed to virtually all insurance companies writing compensation insurance in Wisconsin as well as to several Wisconsin self-insurers,[1] has agreed to observe the above provision. It is included in the application made to the Conference Committee on Open Panels by members wishing to be listed on the panel certified by the Society.

Complaints heard by the Conference Committee on Open Panels indicate, however, that some misunderstanding or lack of information of this provision of the open panel agreement exists among members of the State Medical Society. The Committee therefore requested that the provision be further explained.

The primary objective of all four parties involved in compensation cases—namely, the patient, the physician, the insurance com-

[1] Self-insurers are employers, industrial firms, etc., meeting the requirements of the industrial commission to carry their own compensation insurance and deliver to their employees the benefits provided under the workmen's compensation act. The employer or industrial plant thus becomes an insurance company for the purposes of the workmen's compensation act.

pany, and the employer—is, of course, the prompt recovery of the patient and his early return to work. Good medical care is the prime requisite of this rehabilitation program.

Consultation is an important and integral part of good medical practice and medical care. The insurance companies which, joined together, comprise the American Mutual Alliance and the Association of Casualty and Surety Executives[2], have informed the officers of the State Medical Society through the Society's representatives on the Conference Committee that they are anxious that any injured employee eligible to benefits under the workmen's compensation act receive the benefit of consultation whenever the attending physician feels it is indicated. The insurance companies look on consultations as a good investment if the consultant called in is well qualified by special training and experience to render advice of a specialist character.

The entire plan of unrestricted placement on the panel and free choice of physician by employees entitled to benefits under the workmen's compensation act is an experimental, trial effort by the insurance companies and the profession in Wisconsin to make available to injured employees the services of their family physicians. Failure of physicians to comply with the spirit and letter of the agreement may ultimately lead to its discontinuance in Wisconsin. The reports intimating abuse of the privilege of consultation are scattered and not well defined but have been voiced with such frequency as to give the Conference Committee cause for concern. It would indeed be unfortunate if, for lack of knowledge or other reasons, this reported condition continued and led to cancellation of the open panel agreement.

The Conference Committee on Open Panels urges each member of the Society to secure approval of the insurance carrier, in every instance possible, before a consultant is engaged, that a consultant satisfactory to the attending physician, the patient and the insurance company may be secured.

[2] The American Mutual Alliance and the Association of Casualty and Surety Executives are voluntary associations of the mutual and stock insurance companies of the United States, respectively. A list of members of the two associations, licensed in Wisconsin, appeared in the May, 1939, issue of The Journal, pp. 410 and 412.

THE PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association advocates:

1. The establishment of an agency of federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

NINE COUNTY SOCIETIES REPORT DUES PAID 100 PER CENT AS OF APRIL 26, 1940

Ashland–Bayfield–Iron	Green	Oneida–Vilas
Grant	Juneau	Rusk
	Langlade	Shawano
	Oconto	

. . . . THE PRESIDENT'S PAGES . . . .

"Give the Patient a Break"

UNDER the above title Dr. Hugh Cabot of Boston writes in the American Magazine for April. I would advise those of you who have not read his article to read it at once, as a splendid example of neatly befuddled thinking.

Here is a man who admits that in his heyday he had his office secretary peek through the blinds, look over the patient's automobile and make his professional charge accordingly. It seems to be the history of man that, when he arrives at the carpet slipper age and approaches the uncertainties of the future, he moralizes, confesses his shortcomings and, to ease his conscience, projects the same shortcomings into the characters of others.

Solomon and David, in the Old Testament, were fine examples of hell raisers in their younger days, but remorse caught up with them as age advanced and then, with stomachs that could hold no more, they set down the laws of rectitude.

"And when old age came creeping on
With all its aches and qualms,
King Solomon wrote the Proverbs
And David sang the psalms."

Dr. Cabot admits that he is at variance with the medical profession; in his public utterances and writings he has set himself up (along with others) as the unfailing and unerring prophet. He is going to ride hard against the windmills and topple them over. There are many of his kind, not only in our profession but in others, who, instead of offering constructive criticism within the ranks, would remake us with one sweep. The League of Nations, a dream of a great President, was destroyed by the so-called "irreconcilables," but today I am wondering if many of those who were carried away by their thunder are not sorry, and wish that America had been in the League.

Criticism? Why yes, sure. Let's have plenty of it but let it be constructive and not destructive.

I feel absolutely sure that American Medicine will welcome in its councils the voice of any physician who has anything constructive to offer as to how we can best serve the public most efficiently and at the least cost, but at the same time give it a medicine that you and I would want for ourselves. There are many cures that we still seek but I pray and hope that a cure will be found for that peculiar form of extrorse urge that causes men and women to seek publicity in newspaper columns and magazines, and to have their pictures in the Sunday supplements, whether they have anything to contribute or not.

I say that a man who continually cites alleged instances of young physicians who have or are about to succumb to the temptation of operating on a patient for a fee of $1,000

to pay a due note, conveys to the public a crassly distorted and untrue picture. It seems to me that a man able to command a fee of $1,000 for an operation would be made of such stern stuff that he would not have to call in a consultant, as Dr. Cabot says he did, for an opinion. And for that matter those doctors who are getting $1,000 fees are not practicing here but in the "never, never land."

It would seem charitable, to me at least, to have some of these critics set down on paper the real tales of heroism that have been performed by doctors in this country in the last hundred years. Does anyone ever attempt to tell about a doctor in southern Wisconsin who a year ago dropped dead while carrying a heavy obstetrical grip and trudging through snow drifts, which his car could not negotiate, to a farm house in the line of duty? What about another doctor in northern Wisconsin who was found dead, frozen stiff in front of his stalled car, on his way to respond to a call in the country? In what part of the land are these $1,000 fees? I do not know. But I know of the many men who have thousands upon thousands of dollars unpaid on their books. I know personally of many who never send a bill. I know intimately of the countless numbers who work ceaselessly, humanely and with the good of their patients always uppermost in their minds. The ratio of these unsung heroes to the lounge lizards that Dr. Cabot talks about is as 10,000 is to 1.

It would appear from reading the American Magazine article that Dr. Cabot brings forth a new idea in the way of payment for medical care by the prepayment plan—the voluntary insurance plan, if you wish to call it such. The public should be reminded that Wisconsin has three such experimental plans in operation; that Michigan has one and so have Pennsylvania, California and a host of other states. If that is proved to be the best way to handle the finance of medicine with no depreciation of its quality upon which life itself depends, then we shall proceed upon that line. Many years of trial and error in the practice of medicine have taught us to proceed slowly and thoroughly. If the people would hasten it by a sure-shot, quick-fire method they in the end may be the losers.

As long as our civilization lasts there will always be those people who want the physician of their choice, one they have faith in, one they can trust. The independent and individual practice of medicine shall not perish from the earth for everyone. But if the people are to be preached to effectually and continually to adopt a system of Federal medicine or any other system of medicine which attempts to regiment them, then we may see in this country a peasantry with all the implications of the word,—and the offered "Paradise" may pall upon them.

"Where is the New Jerusalem, Uncle Tom"? cried little Eva.
"Down by de depot, child, down by de depot," said Uncle Tom.

R. G. Arrum

Society Proceedings

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society met on April 11 in St. Vincent's Hospital, Green Bay. Dinner was served in the nurses' dining room of the hospital and a scientific program held in its assembly room. Dr. Ralph Waters of the University of Wisconsin Medical School, Madison, discussed "The Relation of Morbidity to Anesthesia," and because of the practical importance of the subject all anesthetists and floor nurses of St. Vincent's Hospital were invited to hear the talk. Fifty-two physicians and seventy anesthetists and nurses attended.

On April 20 members of the society cooperated with the Crippled Children Division of the State Department of Public Instruction in presenting an orthopedic field clinic in Ashland.

Clark

The Clark County Medical Society elected, on April 4, the following officers:

President—Dr. G. G. Shields, Abbotsford
Vice-president—Dr. J. W. Johnson, Withee
Secretary-treasurer—Dr. W. A. Olson, Greenwood
Delegate—Dr. M. C. Rosekrans, Neillsville
Alternate delegate—Dr. B. H. Dike, Owen

Columbia—Marquette—Adams

The Columbia–Marquette–Adams County Medical Society met at St. Savior's Hospital, Portage, on March 19, for a business meeting. Seventeen physicians attended.

Dane

The Dane County Medical Society met on April 9 at the Madison Club, Madison. Dr. Hans H. Reese of the Wisconsin Psychiatric Institute, Madison, replaced Dr. Eric Oldberg of Chicago on the program. Dr. Oldberg, scheduled to speak on "Some Practical Facts About the Spinal Cord," was unable to come to Madison because of illness. Dr. Reese spoke on "Neuralgia of the Spine."

Dr. M. H. Seevers, Madison, co-editor of The Journal's "Comments on Treatment," discussed "What's New in Pharmacology," and Dr. W. A. Mowry, Madison, "What's New in Allergy."

The Dane County Medical Society and the Dane County Dental Society are cooperating with the Madison board of health and PTA groups in launching the city's annual health round-up. The objective of the round-up is encouraging physical and dental check-ups of all children who will enter school for the first time in the fall.

Dodge

The Dodge County Medical Society met on March 28 at the Lutheran Deaconness Hospital in Beaver Dam at 8 p. m. Dr. H. R. Foerster, Milwaukee, was the guest speaker. His subject was "Eczema and Other Allergic Skin Diseases."

Eau Claire—Dunn—Pepin

The Eau Claire–Dunn–Pepin County Medical Society met in Eau Claire, March 25. Dr. Charles McLennan, Minneapolis, presented a talk on "Treatment of Carcinoma of the Uterus, Vagina and Vulva." Forty-one physicians were present.

Fond du Lac

The Fond du Lac County Medical Society met on March 26 at the Retlaw Hotel, Fond du Lac. Dr. R. H. Stiehm, Madison, addressed the group on "The Early Diagnosis of Asymptomatic Tuberculosis." Thirty physicians attended the meeting.

Green Lake—Waushara

The Green Lake–Waushara County Medical Society met at the Hotel Welcome, Markesan, March 28. The guest speaker on the program was Dr. J. E. Gonce of Madison. He spoke on "Recent Advances in Pediatrics." Twelve members of the society were present.

Jefferson

The Jefferson County Medical Society met at the Carlton Hotel, Watertown on March 28. Twenty-two members of the society attended the dinner, which was served at 6:30 p. m. and viewed motion pictures on appendectomy, cholecystectomy and treatment of gunshot wounds of the abdomen.

Kenosha

The Kenosha County Medical Society cooperated on April 24 with the Crippled Children Division of the State Department of Public Instruction in the presentation of an orthopedic field clinic in Kenosha.

Manitowoc

The Manitowoc County Medical Society met at the Catholic Center, Manitowoc for a luncheon meeting, March 21. Speakers on the program were Dr. Ralph M. Carter, Green Bay, who discussed "Fractures of the Lower End of the Radius," and Mr. Charles Hejda, Manitowoc, who spoke on "Malpractice Insurance." Nineteen attended the event.

Marinette—Florence

Dr. H. F. Schroeder, Marinette, was the principal speaker on a radio broadcast sponsored by the Marinette–Florence County Medical Society, April 4. Dr. J. V. May, president of the society, introduced Dr. Schroeder.

Milwaukee

The Medical Society of Milwaukee County held its monthly meeting in the Milwaukee Athletic Club, April 12, at 8:15 p. m. Dr. H. J. Farrell, Milwaukee, in a program feature entitled "Fifteen Minutes of Preventive Medicine," discussed the syphilis program in Milwaukee county. Dr. Ralph Hamill, associate clinical professor of psychiatry, Rush Medical College, spoke on "Mental Mechanisms of Children." A social hour and buffet luncheon followed the scientific program.

Outagamie

The Outagamie Medical Society met at the Conway Hotel, Appleton, March 28, for dinner and a discussion of plans for the care of the indigent sick in the county. Thirty-eight members attended.

On April 18 the society again gathered at the Conway Hotel, Appleton, to hear a talk by Dr. Arnold Jackson, Madison, on "Diagnosis and Treatment of Diseases of the Thyroid."

Members of the society assisted the Crippled Children Division of the State Department of Public Instruction with an orthopedic field clinic, held in Appleton, April 6.

Polk

Members of the Polk County Medical Society were the guests of Dr. W. B. Cornwall at a 7 p. m. dinner in Amery, March 21. Two physicians from the pediatric department of the University of Minnesota Medical School came from Minneapolis to appear on the scientific program, Drs. Chester Stewart and Paul Dwan. Dr. Stewart discussed "Infant Feeding" and Dr. Dwan, "Convalescent Serum with Special Reference to Scarlet Fever, Measles and Whooping Cough." About twenty attended the meeting.

Portage

Dr. W. W. Bauer, director of the Bureau of Health Education, American Medical Association, Chicago, was the guest speaker at a joint dinner meeting of the Portage County Medical Society and its woman's auxiliary, held at the Hotel Whiting in Stevens Point, April 2. Dr. Bauer spoke on "Health Education vs. Health Racketeering."

While in Stevens Point, April 1–2, Dr. Bauer made five other speeches, appearing before the Rotary and Kiwanis Clubs of the city, two school groups and the Stevens Point Woman's Club.

Price—Taylor

Members of the Price–Taylor County Medical Society met in Murray's Cafe, Phillips, April 3, for a luncheon meeting.

The physicians viewed motion pictures on obstetrical procedures.

The following were re-elected to serve the society as officers for the coming year:

President—H. B. Norviel, Phillips
Vice-President—G. L. Baker, Rib Lake
Secretary—J. L. Rens, Phillips
Censor—D. M. Norton, Medford
Delegate—J. D. Leahy, Park Falls
Alternate delegate—H. B. Norviel, Phillips

Racine

The Racine County Medical Society met on April 18 at the Elks Club of Racine for dinner and a scientific meeting. Program speakers were Dr. Ovid O. Meyer, Madison, who discussed "Newer Concepts of the Anemias and Their Management," and Dr. Samuel Soskin, Chicago, who spoke on "Endocrine Functions of the Anterior Hypophysis."

Several members of the society attended the meeting of the Wisconsin Neurological Society in Racine on April 20.

Sheboygan

Dr. Howard K. Gray of the Mayo Clinic, Rochester, Minnesota, was the main speaker at the meeting of the Sheboygan County Medical Society, held at St. Nicholas Hospital, Sheboygan, April 16. Dr. Gray lectured on "Pathologic Physiology of the Liver."

Walworth

The Walworth County Medical Society and its woman's auxiliary held a dinner meeting on April 11 at the Loraine Hotel, Elkhorn. The guest speaker of the evening was Mr. J. G. Crownhart of the State Medical Society, whose subject was "The Medical Unit."

Washington—Ozaukee

The Washington–Ozaukee County Medical Society held a dinner meeting on March 28 at Smith's Restaurant in Port Washington. Dr. Max Fox, Milwaukee, was the guest speaker. His topic was "The Streptococcic Syndrome." Ten attended the meeting.

Waupaca

The Waupaca County Medical Society met at the Elwood Hotel, New London, on March 26, for dinner and a medical program. Miss Catherine Chambers, Waupaca county public health nurse, addressed the group on the county nursing program. Motion pictures on surgery were shown.

Wood

The annual meeting of the Wood County Medical Society was held at the Hotel Witter, Wisconsin Rapids, April 4. Dinner was served at 6:30 p. m. and then a scientific program was presented by Wisconsin Rapids physicians as follows: "Pulmonary Stenosis," by Dr. Rogers Garrison; "Pyelonephritis in Pregnancy," by Dr. Wallace Nelson; and "Rocky Mountain Spotted Fever," by Dr. L. C. Pomainville.

Officers for 1940 were elected as follows:

President—Dr. P. E. Wright, Wisconsin Rapids
Vice-president—Dr. Hart Beyer, Pittsville
Secretary-treasurer—Dr. R. S. Baldwin, Marshfield

Winnebago

The Winnebago County Medical Society met on April 4 at the Valley Inn, Neenah. Dinner was served at 6:30 p. m. and a general discussion on "Obstetrical Analgesia" was led by Drs. J. M. Hogan, L. O. Helmes and W. A. Wagner of Oshkosh. Dr. E. F. Cummings, the society's secretary, reports a good attendance.

The society sponsored a tuberculin test clinic for Neenah school children in April.

Milwaukee Academy of Medicine

An outstanding program featured the April 16 meeting of the Milwaukee Academy of Medicine. Speakers on the program, presented following a business session, are named below:

I. "Gastrojejunal Colic Fistula"
C. Sherrill Rife, M. D.
Discussion: Frederick A. Stratton, M. D.

II. "Recent Advances in the Diagnosis and Treatment of Thyroid Disease"
George Crile, Jr., M. D.
Cleveland Clinic, Cleveland, Ohio
Discussion: Carl W. Eberbach, M. D.

Milwaukee Oto-Opthalmic Society

The Milwaukee Oto–Ophthalmic Society met at the University Club of Milwaukee on April 9. The members convened at 5:30 p. m. for a business session and discussion of clinical cases. Dinner was served at 6:30 p. m. and then the following program was presented:

"Brittle Bones with Deafness and Blue Sclera; Report of two cases in one family." Meyer S. Fox, M. D., Milwaukee

"Absorption Glasses" (tinted lenses). Mr. Robert Graham, Milwaukee

News Items and Personals

Dr. Armand J. Quick, Milwaukee, co-editor of The Journal's Comment on Treatment section, was one of the featured speakers on the annual meeting program of the Nebraska State Medical Association, held in Omaha, April 22–25.

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Dr. M. G. Peterman, Milwaukee pediatrician, attended the 9th annual meeting of the Tennessee State Pediatric Society and the Tennessee Medical Association, April 9, in Chattanooga, Tennessee. He spoke before the groups on "Convulsions in Childhood."

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Governor Julius P. Heil on April 6 appointed *Dr. Carl W. Eberbach*, Milwaukee, to the State Board of Health for a term expiring in February, 1947. Dr. Eberbach succeeds *Dr. J. J. Seelman*, Milwaukee, who has been a member of the board since 1925.

Governor Heil also announced on April 6 the appointment of Mr. Oscar Rennebohm, Madison druggist, to the State Board of Pharmacy for a term expiring in April, 1945. Mr. Rennebohm replaces Dr. Edward Kremers, Madison.

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Dr. William A. Werrell, Madison, was elected April 15 to succeed the late Dr. H. E. Purcell as medical representative on the Madison board of health.

Dr. Cornelius A. Harper, Madison, on April 1 began his thirty-seventh year of service as state health officer of Wisconsin. "The work keeps on expanding," he stated, "but the fundamentals do not change. Behind it all is the steadfast cooperation of the Wisconsin people and their family physicians."

Dr. Harper was named administrative head of the board of health in 1904 by Governor Robert M. La Follette.

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Dr. I. F. Thompson, Racine, and *Dr. G. J. Hildebrand*, Sheboygan, have been named president and secretary, respectively, of a newly formed organization of forty-one representatives of southern and eastern Wisconsin health departments to cooperate with the state department of agriculture in the enforcement of food products legislation.

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Dr. E. L. Schroeder was reelected mayor of Shawano, April 2.

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A memorial fund, set up in honor of the late Dr. G. H. Conklin, Superior, is being utilized to buy needed equipment for rehabilitation classes at the *Middle River Sanatorium*, Hawthorne. A former superintendent of the sanatorium, Dr. Conklin retained an active interest in its work up to the time of his death.

Dr. Mancel T. Mitchell, son of the late Dr. R. E. Mitchell, Eau Claire, has accepted a position as obstetric consultant to the Division of Maternal and Child Health, Utah State Board of Health, Salt Lake City.

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"Medicine As It Was Practiced in Wisconsin in the Horse and Buggy Days," was the subject of the 6th annual Bardeen Memorial Lecture, presented by *Dr. F. P. Daly*, April 25 at the Service Memorial Institutes, Madison. Dr. Daly, now a member of the Wisconsin State Board of Health, was engaged in general practice for thirty-five years.

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Dr. Fred G. Johnson, Jr., has opened offices for the general practice of medicine and surgery in Superior. He is the son of *Dr. Fred G. Johnson*, Iron River, councilor for the Eleventh District, State Medical Society.

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"The fear of being wrong is a predominant element in childhood," Dr. Ralph C. Hamill of Rush Medical College, Chicago, told an audience of about 300 in the course of a public lecture held at the Waukesha High School in April. The lecture was sponsored by the *Rogers Memorial Sanitarium*, Oconomowoc.

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Dr. Arnold Jackson, Madison, attended a meeting of the American Association for the Study of Goiter in Rochester, Minnesota, April 15–17. He was elected an executive councilor of the association.

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Dr. F. J. Huberty was reelected city physician and health officer of Appleton at a meeting of the Appleton city council, April 16.

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Problems of health in industry were considered at a dinner meeting of the Wisconsin Industrial Nursing Conference at the Milwaukee Athletic Club, April 19. Physician-speakers on the program included *Drs. O. A. Sander* and *A. I. Rosenberger*, Milwaukee.

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Dr. Louis W. Nowack was named commissioner of health of Watertown, April 17, by Mayor W. A. Nack of that city.

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Dr. Richard A. Jensen was elected city physician of Menasha on April 16 by the Menasha city council.

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Two columns in the *Sheboygan Press* were devoted to a talk delivered by *Dr. D. W. Roberts* of Sacred Heart Sanitarium, Milwaukee, before the Sheboygan Woman's Club, in April. In the talk, entitled "Keeping Mentally Fit," Dr. Roberts described twelve personality types and discussed present trends which call for emphasis on mental hygiene.

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Dr. I. Schultz, Mazomanie, delivered an address on "Child Welfare," at the April meeting of the Mazomanie Rural Club.

The development of medical care in industry was traced by *Dr. G. H. Williamson*, Neenah, in a talk given before the Neenah Club, April 1.

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An all-day clinic program was presented by the Marquette University School of Medicine Alumni Association, May 8, in the school's auditorium, as follows:

Morning Session

9:30–10:00	Registration at Medical School.
10:00–10:30	Dr. Armand J. Quick. Recent Advances in the Knowledge of the Control of Hemorrhage.
10:30–11:00	Dr. Eben J. Carey. Recent Advances in the Applied Anatomy of the Sympathetic Nervous System.
11:00–11:30	Dr. Harry Beckman. Development of the New Chemotherapeutic Agents (Sulfanilamide, etc.).
11:30–12:00	Dr. Joseph C. Bock. Practical Aspects of Diabetes Mellitus.
12:00– 1:30	Recess. Free lunch for all registered medical students and alumni served in Student Recreation Room.

Afternoon Session

1:30– 1:50	Dr. Joseph M. King. The Surgery of Obstructive Jaundice.
1:50– 2:10	Dr. Fred W. Madison. Capillary Factors in Abnormal Bleeding.
2:10– 2:30	Dr. David Cleveland. Surgery of the Sympathetic Nervous System.
2:30– 2:50	Dr. Francis D. Murphy. The Use of Sulfanilamide and Allied Compounds in Clinical Medicine.
2:50– 3:10	Dr. Conde F. Conroy. Bleeding Ulcers of the Stomach.
3:10– 3:30	Dr. Walter M. Kearns. Clinical Application of Testosterone.
3:30– 3:50	Dr. Ronald S. Cron. The Clinical Use of the Female Sex Hormones.
3:50– 4:10	Dr. Frederick A. Stratton. Benign Lesions of the Breast.

During the noon recess, after luncheon, there were practical demonstrations of experimental work on malaria by Dr. Beckman and on blood coagulation by Dr. Quick. In the evening senior medical students were the guests of the Alumni Association at a banquet at the Schroeder Hotel. The guest speaker at the banquet was Dr. James P. Simonds, professor of pathology, Northwestern University School of Medicine, Chicago. His subject was "The General Practitioner and Modern Medicine."

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Dr. H. Curtis Johnson, Madison, recently spent a month in training with the "streamlined" 6th division of 9,000 men at Camp Jackson, near Columbia, South Carolina.

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A large delegation of Wisconsin physicians and hospital employees attended the 11th annual meet-

ing of the Tri-State Hospital Association in Chicago, May 1–3.

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Dr. W. C. Reineking, superintendent of Lakeview Sanatorium, Madison, was reelected president of the Wisconsin Sanatorium Superintendents' Association at a meeting of the association in Milwaukee, April 5.

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During the month of April, physicians throughout the State made talks on cancer care and prevention, in connection with the April campaign of the Women's Field Army for the Control of Cancer. Many of them, with civic leaders and representatives of the Field Army, attended the high point of the April campaign, a dinner meeting in Milwaukee, April 19, honoring *Dr. Rock Sleyster*, Wauwatosa, president of the American Medical Association. The main speaker at the dinner was Dr. Frank Rector, Evanston. His subject was "Why Women Fight Cancer." Others on the program were *Dr. R. G. Arveson*, Frederic, president of the State Medical Society, and *Dr. Charles Fidler*, Milwaukee.

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Dr. E. H. Rettig, Milwaukee, discussed the treatment of disorders caused by overwork and a preponderance of mental over physical activity at a meeting of the Milwaukee Teachers' Association, April 10.

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"The History of Socialized Medicine," was the topic discussed by *Dr. R. G. Arveson*, Frederic, president of the State Society, at a meeting of the Business and Professional Women of Eau Claire on April 9. Among guests at the meeting were *Dr. and Mrs. J. C. Baird*, Eau Claire.

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Coming Events

Lahey at Madison, May 20.—Members of the State Medical Society are invited to attend a joint meeting of the Dane County Medical Society and the Third Councilor District of the State Medical Society to be held in Madison on Monday, May 20. The meeting will open at 2 p.m. in the auditorium of the Service Memorial Institutes on the University of Wisconsin Medical School campus, with a series of dry clinics on medicine and surgery, presented from 2 to 5 p.m. by Dr. Frank H. Lahey of the Lahey Clinic, Boston, and Drs. Robert E. Burns and Ovid O. Meyer of the University of Wisconsin Medical School, Madison.

At 6:30 p.m. a special dinner meeting of the Dane County Medical Society will be held in Tripp Commons, Memorial Union Building, Madison. This dinner is to honor Dr. Henry V. Bancroft, Blue Mounds, who this year has been fifty-five years in practice. Following the dinner, Dr. Lahey wil give an address. Dinner reservations must be made through Dr. Clair O. Vingom, secretary of the Dane County Medical Society, Madison, and accompanied by $1.25 to cover the cost of the dinner.

Postgraduate Course, University of Chicago and Chicago Lying-In Hospital.—Through the cooperation of the Illinois State Department of Public Health, the Division of Child Hygiene, and the Children's Bureau of the U. S. Department of Labor, the Department of Obstetrics and Gynecology of the University of Chicago and The Chicago Lying-In Hospital are offering five to six weeks postgraduate courses in obstetrics for practitioners during the next several months.

In general, the major portion of the didactic work will be done by Dr. Melbourne W. Boynton and Dr. John H. Morton, but all of the other members of the Department of Obstetrics and Gynecology will participate in various degrees in these postgraduate courses.

Except for a deposit of $25 ($10 is returned at the completion of the course) the only expense to the individual will be that of his board and room, and his own personal incidental expenses. The enrollment for each course will be kept small to promote a direct and personal relationship between the practitioners and the staff.

The first three periods are set for April 29, 1940 to June 8, 1940, June 17, 1940 to July 20, 1940, and July 22, 1940 to August 24, 1940.

Applications and inquiries should be addressed to: Postgraduate Course, Department of Obstetrics and Gynecology, University of Chicago, 5848 Drexel Avenue, Chicago, Illinois.

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Reunion Banquet, Jefferson Medical College.—Wisconsin physicians who are graduates of Jefferson Medical College will be interested to know that a reunion banquet of the College is being held, in connection with the convention of the American Medical Association in New York City, at the Murray Hill Hotel, on Park Avenue at 41st Street, 7 p.m., June 12. Tickets are $2.50 each. Dr. Thomas F. Dunigg, chairman of the dinner committee, writes: "Requests for reservations may be addressed to me at the Murray Hill Hotel, Park Avenue at 41st Street, New York City, but physicians who neglect to make reservations—'come anyway.'"

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Wisconsin State Board of Medical Examiners.—The next regular examination of the Wisconsin State Board of Medical Examiners will be held at the Schroeder Hotel, Milwaukee, June 25–28. Applications for reciprocity will also be considered at this meeting.

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National Gastroenterological Association, 5th Annual Convention.—Scientific sessions will be held June 4–6 at the Hotel Roosevelt, 45th St. and Madison Avenue, New York City. There will be a program of social activities for families and friends of physicians attending the sessions. Detailed information may be obtained from Dr. Henry Kendall, 16 East 96th St., New York City.

Milwaukee Society of Clinical Surgery to Hold Seminar on Oxygen Therapy.—At a dinner meeting, to be held in the University Club, Milwaukee, at 6:30 p.m., Tuesday, May 28, the Milwaukee Society of Clinical Surgery will sponsor a seminar on the medical use of oxygen. The program to be presented is as follows:

Physiologic Aspects of Oxygen Therapy—Dr. Harry Beckman.
Clinical Indications for Oxygen Administration —Dr. H. A. Cunningham.
Mechanical Considerations of Oxygen Therapy Apparatus—Mr. James I. Banash.
Clinical Response to Oxygen Therapy — Dr. Ralph M. Waters.

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Meeting of Section on Radiology, State Medical Society.—The meeting will be held at La Crosse, Friday and Saturday, May 17–18. The Friday afternoon session will be held at the Stoddard Hotel, where a symposium on laminagraphy will be participated in by *Drs. H. W. Hefke, J. L. Armbruster, J. E. Habbe* and *S. A. Morton,* Milwaukee, and *L. W. Paul,* Madison. The guest speaker will be Dr. H. Dabney Kerr, head of the department of radiology, University of Iowa. A dinner meeting will be held Friday evening on the boat "Blackhawk" on the Mississippi River. Dr. Kerr will speak again at this session.

On Saturday morning there will be a business meeting at the Hotel Stoddard followed by a round table presentation of cases. Among those who will present case reports will be *Drs. H. W. Hefke,* Milwaukee; *F. H. Kuegle,* Janesville; *H. M. Coon,* Statesan; *J. E. Habbe,* Milwaukee; *J. A. Evans,* La Crosse; *I. I. Cowan,* Milwaukee; and *R. P. Potter,* Marshfield.

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Third Annual Meeting, Jackson Clinic–Methodist Hospital Alumni.—The meeting will be held at the Jackson Clinic, May 31 and June 1. Drs. D. L. Williams, Madison, Harry Vander Kamp, Baraboo, and Luther E. Holmgren, Madison, are in charge of the program.

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Wisconsin General Hospital Meeting.—Dr. Eugene E. Neff, Madison, professor of ophthalmology, University of Wisconsin Medical School, will address the staff of the Wisconsin General Hospital on "Glaucoma," and Dr. Claude Miller of the department of ophthalmology will present a case report, at a meeting on May 21, 7:45 p. m., Room 230, Service Memorial Institute Building, Madison.

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Basic Science Examinations.—The next examination by the Wisconsin State Board of Examiners in the Basic Sciences will be held June 1, 1940, at the Hotel Pfister, Milwaukee. Application forms may be obtained from Prof. Robert N. Bauer, secretary of the Board, 3414 West Wisconsin Ave., Milwaukee.

BIRTHS

A daughter to Dr. and Mrs. Leif H. Lokvam, Kenosha, February 11.

A daughter to Dr. and Mrs. C. W. Aageson, Madison, April 23.

A daughter to Dr. and Mrs. L. B. McBain, Appleton, in March.

A son to Dr. and Mrs. James Garland, Milwaukee, March 23.

MARRIAGES

Dr. Phillip H. Halperin, Madison, and Miss Dorothy Milgram, Kansas City, Mo., on April 9.

Dr. W. J. Mauermann, Beloit, and Miss Lois Alton, Madison, on April 2.

DEATHS

Dr. Joseph L. Barber, Marathon, died on April 6, after an illness of several months. He was 76 years of age.

Dr. Barber, who was born in Hayton, Calumet county, Wisconsin, had practiced medicine in Marathon for thirty-four years. Before taking up residence in Marathon, he practiced in Kaukauna and Greenwood.

The doctor was active not only in medical but in political circles. He was a former state senator and assemblyman. He was president of the village of Marathon and a member of the Marathon county board of supervisors for several years.

Dr. Barber was a member of the Marathon County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow, two daughters and a son.

Dr. Alvin J. Brah, Milwaukee, died suddenly on March 26 of a heart attack. He was 54 years of age.

Dr. Brah was graduated from the College of Physicians and Surgeons, Milwaukee in 1908. He began the general practice of his profession in Milwaukee in the same year. In 1929 he went to Vienna for postgraduate study and on his return to Milwaukee he specialized in the treatment of diseases of the eye, ear, nose and throat.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow, two sons and a daughter.

Dr. William A. Deerhake, Waupun, died on April 10 of injuries received in an automobile accident. He was superintendent of the Central State Hospital for the Criminal Insane, located in Waupun. Mr. Frank Klode, director of the executive staff of the State Board of Public Welfare, stated: "His loss will be felt deeply both in the state service and the entire medical profession." Mr. A. W. Bayley, secretary of the executive staff of the welfare board, credited Dr. Deerhake with doing "a splendid job in one of the toughest positions in the state service." Dr. Deerhake was the third superintendent at the Waupun institution, being preceded in office by Dr.

J. F. Brown, deceased, and Dr. Rock Sleyster, Wauwatosa.

He was born in Ohio in 1886 and was graduated from the Indiana University School of Medicine, Bloomington–Indianapolis, in 1908. He engaged in public health work in Michigan, Ohio and Washington, D. C., before moving to Waupun in 1926. He served as captain in the medical corps for two years during the World War.

In 1934, when the Waupun institution was the subject of extended investigation by legislative and special citizens' committees, Dr. Deerhake was praised for the high quality of his work and for his model record system. In 1936, Dr. Deerhake introduced musical activity at the Waupun hospital for its therapeutic value to mental patients.

He was a member of the Fond du Lac County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow, a daughter and a son.

Dr. Lyman A. Steffen, Antigo, died on April 10 after a short illness, at the age of 53 years.

Dr. Steffen, who was health officer of Antigo at the time of his death, was graduated in 1912 from Rush Medical College, Chicago. For a few years he practiced in Chicago and Virginia, Minnesota; in the fall of 1918 he returned to Antigo, his birthplace, to engage in medical practice with his father.

Dr. Steffen served overseas during the World War and held the rank of captain. He was a member of the Langlade County Medical Society, the State Medical Society of Wisconsin, the American Association of Railway Surgeons, and the Chicago and Northwestern Surgical Association. He was a Fellow of the American Medical Association.

Surviving him are his widow and two daughters.

SOCIETY RECORDS

New Members

A. D. Andrus, Ashland.

Ernest Newman, 503 Fourth Street, Wausau.

S. C. Peterson, Luck.

L. A. Campbell, Jr., Clayton.

May R. Wells, 403 North Murray Street, Madison.

J. T. Sprague, 2520 East Washington Avenue, Madison.

O. E. Damp, Birnamwood.

N. V. Sandin, Ashland.

H. H. Heitzman, 536 South Webster Avenue, Green Bay.

R. T. Rank, 238 West Wisconsin Avenue, Milwaukee.

E. A. Heipp, 1022 North Tenth Street, Milwaukee.

C. S. Rife, 324 East Wisconsin Avenue, Milwaukee.

H. M. Levin, 238 West Wisconsin Avenue, Milwaukee.

Ruth Schoenkerman–Stern, 606 West Wisconsin Avenue, Milwaukee.

Frederick Oswald, 2712 North Holton Street, Milwaukee.

D. J. Taft, Tomah Clinic, Tomah.

T. D. Elbe, Port Washington.

R. F. Braun, Clintonville.

J. J. Colgan, 953 North Twenty-seventh Street, Milwaukee.

R. H. Dorr, 964 North Twenty-seventh Street, Milwaukee.

R. W. Mann, 425 East Wisconsin Avenue, Milwaukee.

A. A. Sverdlin, 1673 South Eleventh Street, Milwaukee.

E. A. Miller, 300 Main Street, Watertown.

C. M. Carney, Fairbanks, Morse & Company, Beloit.

H. W. Housley, Neillsville.

E. W. Witcpalek, Kewaunee.

Changes in Address

J. K. Stewart, Madison, to Jane Lamb Memorial Hospital, Clinton, Iowa.

R. H. Slater, Marion, to Granton.

A. J. Harris, Friendship, to Adams.

G. E. Seaman, Winnebago, to State Capitol, Madison.

D. S. Wenger, Milwaukee, to 1513 Alice Street, Wauwatosa.

H. V. Malin, Whitehall, to Thorp.

M. F. Stricker, Tomahawk, to Middleton.

S. S. Salinko, Los Angeles, California, to 1656 South Eighth Street, Milwaukee.

A. T. Hume, Chetek, to Monticello, Illinois.

R. H. Harris, Prairie du Sac, to Hotel Hanford, Mason City, Iowa.

E. R. Daniels, Statesan, to 7606 Stickney Avenue, Wauwautosa.

A. P. Hable, Gilman, to Loyal.

CORRESPONDENCE

PNEUMOTHORAX REFILLS

WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION
Health Service Building

Milwaukee, April 10, 1940.

Mr. J. G. Crownhart,
Managing Editor,
Wisconsin Medical Journal,
Madison, Wisconsin.

My dear Mr. Crownhart: Every once in a while we receive requests from patients outside of the state who have come into Wisconsin for a shorter or longer stay. These patients are under pneumothorax treatment and, therefore, require refills at definite intervals. The requests are usually for the names of physicians or hospitals equipped to do this type of work. If physicians who are equipped to do pneumothorax refills will send their names to this office, we will be very happy to keep a register so that when these requests come in proper reference could be made.

I wonder if you will kindly publish this letter so that this request may go out to the medical profession? With kindest regards, I am

Yours very truly,

OSCAR LOTZ, M. D.,
Executive Secretary.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. Frank W. Pope, Racine, President
Mrs. Donne F. Gosin, Green Bay, President-Elect
Mrs. Thad W. Ashley, Kenosha, Vice President
Mrs. Homer M. Carter, Madison, Recording Secretary
Mrs. Charles E. Constantine, Racine, Corresponding Secretary
Mrs. Edwin P. Bickler, Milwaukee, Treasurer
Mrs. William M. Jermain, Milwaukee, Parliamentarian

COMMITTEE CHAIRMEN

Archives—
Mrs. Cornelius A. Harper, Madison
Convention—
Mrs. Eben J. Carey, Milwaukee
Finance—
Mrs. Arthur J. McCarey, Green Bay
Hygeia—
Mrs. Irenaeus N. Tucker, Racine
Organization—
Mrs. Ernest S. Schmidt, Green Bay
Philanthropic—
Mrs. Edgar F. Andre, Kenosha
Press and Publicity—
Mrs. Arnold S. Jackson, Madison
Program—
Mrs. James C. Hassall, Oconomowoc
Public Relations—
Mrs. Ira F. Thompson, Racine
National Exhibit (Special Committee)—
Mrs. E. Lee Lochen, Waukesha

National Convention

By MRS. ROLLO K. PACKARD
President, Woman's Auxiliary, American Medical Association
Chicago

THE annual convention of the Woman's Auxiliary to the American Medical Association will be held at the Pennsylvania Hotel in New York City, June 10–14, 1940.

There will be numerous meetings of the Auxiliary that the members will enjoy attending whether or not they are officers. Many problems will be discussed at the general sessions that will be interesting and should be helpful to all members of the Auxiliary, and particularly to the state and county officers. Mrs. Carlton F. Potter, convention chairman, is working hard to arrange for various types of entertainment, including the visiting of many interesting places in New York City.

I wish to extend an invitation to the members of the Auxiliary and all other women attending the convention to attend the meetings and functions outlined below. I feel that the Auxiliary will profit much by your attendance and that much thought and stimulation may come from these meetings.

The program of the activities will appear later in detail. The following arrangements have been made for the general sessions, luncheons, and conferences.

Sunday, June 9

Registration—Grand Ball Room Floor, Pennsylvania Hotel

Monday, June 10

A. M.

10:00 National Board Meeting, Pennsylvania Hotel

Tuesday, June 11

A. M.

9:00 Pennsylvania Hotel. The first general session will be held; reports of national officers and chairmen of standing committees will be presented.

P. M.

12:30 Pennsylvania Hotel. Luncheon in honor of past national presidents. Auxiliary members and all visiting women are invited. Dr. Rock Sleyster, president of the American Medical Association, will extend greetings. Guest speaker: Dr. Morris Fishbein, editor of Journal of American Medical Association and Hygeia.

3:00 Pennsylvania Hotel. Conference for president and chairmen of committees, the following presiding:

Organization, Mrs. D. W. Thomas
Program, Mrs. W. F. Donaldson
Public relations, Mrs. R. E. Mosiman
Legislation, Mrs. A. A. Herold
Hygeia, Mrs. E. J. Carey
President-elect, Mrs. V. E. Holcombe

8:00 Pennsylvania Hotel. Opening meeting of American Medical Association.

Wednesday, June 12

A. M.

9:00 Pennsylvania Hotel. The second general session will be held; the reports of the presidents from thirty-eight states will be given. Election of officers for ensuing year and installation of officers.

P. M.

1:00 Pennsylvania Hotel. Annual luncheon in honor of the national president.

Address: Dr. N. V. Van Etten, president-elect of American Medical Association.

Guest speaker: Alphonse M. Schwitalla, S. J., Ph. D., dean, St. Louis University School of Medicine.

Thursday, June 13

A. M.

9:30 Executive committee meeting.

10:00 Post convention board meeting.

P. M.

6:30 Pennsylvania Hotel. Annual dinner. This event has been listed previously as "Bring-Your-Husband Dinner," but has now been changed because many women attending past conventions did not participate as they were under the impression they had to bring their husbands. All members of the Auxiliary, as well as visiting women, are invited to come, either alone or with their husbands, as they desire.

9:00 Waldorf Astoria Hotel. Reception for president of American Medical Association, and ball.

COUNTY AUXILIARY PROCEEDINGS

Dane

The Woman's Auxiliary to the Dane County Medical Society met April 17 at the home of Mrs. W. H. Krehl, Madison.

The assisting hostesses were: Mrs. J. F. Gallagher, Mrs. L. E. Holmgren, Mrs. H. N. Winn, Mrs. T. W. Tormey, Jr., and Mrs. E. H. Grumke.

A short business session was held, after which bridge was played.

Dodge

Dr. J. H. Karsten of Horicon addressed the Beaver Dam Woman's Club on the subject "Shall We Formulate a New Concept of Hospitalization?" at its meeting in the K. C. Club Rooms on April 15. The program was sponsored by the Woman's Auxiliary to the Dodge County Medical Society.

Dr. Karsten traced the development of hospitalization since early times, stating that it is not a new problem but one that has existed since centuries before Christ. He concluded by summarizing as follows: (1) A hospital should be a line of first defense rather than a place of last resort; (2) the popular attitude toward hospitalization through the years has been for some reason one of aversion; (3) hospitals in general are economically sound and for childbirth in particular; (4) the more generally hospitalization is practiced the more its costs should decrease in comparison with established common practice; and (5) if a new concept and mental attitude toward hospitalization is to be formulated, such formulations must come out of consideration given the matter by progressive, interested groups.

Douglas

The Woman's Auxiliary to the Douglas County Medical Society sponsored during the first week in April the appearance in Superior of Dr. P. C. Barton of Chicago, director of the Bureau of Investigation of the American Medical Association.

On April 4 Dr. Barton discussed "Patent Medicines" at a dinner meeting of the Kiwanis Club, and on the following morning he appeared before the student bodies at Central and East High Schools to discuss this same subject. On the afternoon of April 5 he was the guest speaker before the Superior Woman's Club in Memorial Hall, his subject being "Cosmetics."

On the evening of April 4 Dr. Barton was the speaker at a joint dinner meeting of the Douglas County Medical Society and its auxiliary in Badger Inn of the Hotel Superior. His subject was "Drugs and Foods." Mrs. E. L. Campbell and Dr. T. J. Doyle were in charge of arrangements.

Fond du Lac

Plans for parties to be given soon at the homes of Mrs. F. M. McGauley and Mrs. C. W. Leonard were made at a dinner meeting of the Woman's Auxiliary to the Fond du Lac County Medical Society on March 26 at the home of Mrs. J. E. Twohig of Fond du Lac.

Spring flowers were used in decorations.

Mrs. H. E. Twohig, president, appointed a nominating committee consisting of Mrs. L. C. Gardner, Mrs. H. R. Sharpe, and Mrs. V. A. Toland to prepare a slate of officers.

Kenosha

Mrs. L. M. Rauen, chairman of press and publicity of the Woman's Auxiliary to the Kenosha County Medical Society, has reported that a delightful afternoon tea was given during April at the home of Mrs. B. S. Hill of Kenosha, when members of the auxiliary entertained the wives of the druggists in the city.

Special music was offered by Mary Clare Ulrich, violinist, accompanied by Eugene Hopkins. A colorful centerpiece of spring flowers adorned the tea

table, where Mesdames E. F. Andre, J. H. Holm, and A. L. Mayfield, and Dr. Helen Binnie presided.

Assisting Mrs. Hill in entertaining were Mesdames G. J. Schwartz, C. G. Richards, E. F. Andre, A. M. Rauch, J. P. Graves, C. M. Creswell, L. H. Lokvam, and Alexander Schlapik.

La Crosse

Mrs. J. C. Harman of La Crosse, secretary of the Woman's Auxiliary to the La Crosse County Medical Society, has reported that their membership is now thirty-eight, the following new members having joined the organization at their meeting on April 2: Mrs. George Schneeberger, Mrs. F. H. Wolf, and Mrs. R. L. Eagan of La Crosse, and Mrs. R. H. Goedecke of West Salem.

The members of the auxiliary were entertained at a tea on April 2 by Mrs. Adolph Gundersen, assisted by Mesdames S. B., A. H., and Gunnar Gundersen. Mrs. G. W. Lueck, Miss Frances Sill, and Mrs. P. T. Walters presided at the tea table.

Guests included instructors from Emerson School, as well as visitors from Houston, Viroqua, and West Salem.

Manitowoc

The members of the Woman's Auxiliary to the Manitowoc County Medical Society held a luncheon at the Century Tea Room in Two Rivers on March 28. The chairman of press and publicity for the organization, Mrs. T. A. Teitgen of Manitowoc, reported an attendance of fifteen members. Following a short business meeting bridge was played, each member contributing a 25-cent prize.

Milwaukee

The April meeting of the Woman's Auxiliary to the Medical Society of Milwaukee County was held on Friday, April 12, at the Milwaukee Athletic Club. One hundred and thirty-five members and guests attended.

Cactus plants decorated the tables which were presided over by Mesdames W. F. Grotjan, A. R. Grob, H. K. Allebach, R. J. Bach, C. J. Becker, J. Y. Malone, D. A. Cleveland, and S. E. Coffey.

Mrs. C. D. Partridge, president, introduced the chairmen of the standing committees, who gave their reports. Mrs. G. J. Pugh, membership chairman, presented the following new members: Mrs. P. P. Goodman, Mrs. Armin Steckler, and Mrs. J. M. Sullivan.

Spanish music by Mrs. R. A. Rybold, violinist, accompanied by Mrs. Paul Ringler, was a delightful background for the colored movie travelogue on Mexico which followed. Miss Kathleen Clarke, guest speaker, described in a most interesting manner her travels "South of the Border."

Preceding the regular meeting the study group met to continue its discussion of the Wagner Health Bill.

The next meeting will be a Mother's Day luncheon at the Hotel Schroeder on May 10.

Outagamie

Girl Scouts of Troop 16, Orthopedic School, were guests at a meeting of the Woman's Auxiliary to the Outagamie County Medical Society on March 28 at the home of Mrs. R. T. McCarty in Appleton. Besides the eleven scouts, the following troop leaders were present: Miss Marion Binzel, Milwaukee, and Miss Charlotte Leins, West Bend, both of them Lawrence College students, Miss Florence Miller and Miss Carla Naber of Appleton, and Mrs. Basil McKenzie, Appleton Girl Scout commissioner. The girls presented a program which included a tap dance by Elaine Hoffman, enactment of a model meeting and a shadow play "Little Red Riding Hood," for which Dorothy Hedberg wrote and read the script.

After the Girl Scout program Mrs. E. J. Zeiss of Appleton, a member of the auxiliary, gave a paper on the Wagner Bill.

At the business meeting it was announced that Mrs. R. G. Arveson of Frederic, wife of the president of the State Medical Society of Wisconsin, would be a guest at the meeting on May 16. Also scheduled for May, although the exact date was not announced, is the annual open house meeting at which the auxiliary will be hostess at the Masonic Temple. Mrs. D. W. Curtin of Kimberly has been appointed chairman of the meeting.

Portage

The Woman's Auxiliary to the Portage County Medical Society and the Stevens Point Woman's Club held a joint meeting on April 1 in the library club rooms. Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association, spoke on "Vim, Vigor, and Vegetables," and the P. T. A. Mothers' Chorus, directed by Miss Dorothy Vetter and accompanied by Mrs. L. S. Dietrich, presented a musical program.

Hostesses for the social hour were: Mrs. H. P. Benn, chairman, Mrs. E. P. Crosby, Mrs. R. T. Reinholdt, Mrs. W. F. Cowan, and Mrs. J. B. Beach.

Racine

As announced in the letter from Mrs. F. W. Pope of Racine, president of the State Auxiliary, in the April issue of the Wisconsin Medical Journal, the Woman's Auxiliary to the Racine County Medical Society on April 9, held a large public relations meeting. This meeting, which followed the program of the national and state medical auxiliaries, was under the chairmanship of the Public Relations Committee and was intended to bring to the public the objectives of the auxiliary, both state and national. Under the co-chairmanship of Mrs. E. W. Schacht and Mrs. I. N. Tucker of the Public Relations Committee, announcements were issued to about 225 organizations inviting the president and one other member of each group to attend.

Other committee members who assisted in the arrangements were as follows:

Program—Mrs. C. E. Constantine, chairman, and Mrs. A. W. Adamski.

Tea—Mrs. W. E. Buckley, chairman, and Mesdames H. B. Beeson, J. C. Doctor, S. J. Faber, G. N. Gillett, H. J. Brehm, J. F. Henken, A. M. Lindner and R. J. Schacht.

Invitations—Mrs. H. B. Keland, chairman, and Mrs. W. C. Hanson and Mrs. W. C. Roth.

Mrs. Frank W. Pope, state president, and Mrs. A. S. Pfeiffer, county president, welcomed the guests, and Mrs. I. F. Thompson, state chairman of public relations, served as general adviser for the project.

The guest speaker was Mr. G. B. Larson, assistant secretary of the State Medical Society of Wisconsin, who explained what the State Society is doing in its study and research efforts in the field of voluntary sickness insurance in Wisconsin. He also included some discussion of the Wagner Bill, and following his talk, answered questions on various phases of his work.

Rock

Sixteen members of the Woman's Auxiliary to the Rock County Medical Society held a dinner meeting on March 26 in the Monterey Hotel, Janesville. Mrs. H. E. Kasten of Beloit, secretary, conducted the meeting. An informal talk on Europe was given by Miss Joyce Hartman, Beloit, Y. W. C. A., who attended a youth congress in Europe last summer. Mrs. L. H. Walz, New York City, who is visiting her mother, Mrs. F. E. Sutherland, told of the social service work which her husband's church is doing in New York.

Sheboygan

"When thirty young people bicycle for thirty days through a foreign country, they come away with vivid impressions of its geography, its roads, its villages, its forests and rivers, and its people," declared Miss Margaret Wernecke, instructor at Plymouth High School, in a travel talk before the Woman's Auxiliary to the Sheboygan County Medical Society at its luncheon meeting on April 3 at the Candle Glow in Plymouth.

In the interesting travelogue, based on her experiences abroad last summer, Miss Wernecke described the youth hostels, and said in part: "The hostels are so located that the youth must pass through the most historic or beautiful spots of a village or city in order to reach them. It is a very subtle method of teaching history and developing a love of one's own country. What better way can we in America find for encouraging a love of these mountains, rivers, lakes, and plains which combine to make this the country we love? Herein lies the road to democracy and patriotism."

Summarizing her impressions, Miss Wernecke said, "Eight hundred miles through Germany over cobblestone roads may sound like difficult traveling. Thirty-one days among a people who are kind and friendly enough to be our neighbors seemed like a week end."

Winnebago

After a one o'clock luncheon at the Column Tearoom in Neenah, members of the Woman's Auxiliary to the Winnebago County Medical Society went to the home of Mrs. G. H. Williamson of that city for their business meeting and program. Mrs. R. H. Bitter, the president, presided and gave a report on the January meeting in Milwaukee of the Board of Directors of the Woman's Auxiliary to the State Medical Society of Wisconsin.

In the Hygeia committee report Mrs. Williamson told that twenty-five subscriptions to this publication had been placed in beauty parlors of the county. She then presented some outstanding articles from the magazine, the first being called "The Hair," and the second a humorous piece called "Prenatal Care of Fathers." Interesting too was the article she read on the surprising increase of smallpox due to neglect of vaccination. The last was a beautiful tribute called "A Prayer," written by the Rev. George Stewart for the late Dr. Harvey Cushing.

A last reminder to make your reservation for the 18th Annual Convention of the Woman's Auxiliary to the American Medical Association to be held at the Hotel Pennsylvania, New York City, June 10 to 14, 1940. New York has much to offer aside from the convention and we are sure you will not want to miss the opportunity of visiting New York this year.

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Osteopaths Forbidden to Vaccinate

THAT osteopaths may not vaccinate against smallpox under the Medical Practices Act was the opinion recently given by John E. Martin, Attorney General of Wisconsin, to Clarence G. Traeger, District Attorney of Dodge County.

The Attorney General said that "vaccination against smallpox is plainly within the meaning of the term 'practice of medicine' (and) it is also clear that vaccination is not included in osteopathy . . ." After concluding that vaccination is not within the meaning of the term "surgery" as that word is used in the Medical Practices Act, Attorney General Martin said:

"The point is that if an osteopath is qualified to practice medicine he may become licensed to do so, but if he is not so licensed his qualifications alone do not permit him to invade the field. If conditions in the field of osteopathy have so changed that it is no longer limited to curing by the adjustment of misplaced parts of the body, without drugs, this can be recognized by amending the statutes. See: *State v. Sawyer*, 36 Idaho 814, 214 Pac. 222 (1923). In the meantime, persons licensed to practice osteopathy and surgery may not enlarge the legal scope of their activities merely by undertaking to perform functions properly belonging to the practice of medicine alone."

Minutes of the Council; Milwaukee, March 31, 1940

1. Call to Order

The Council was called to order by Chairman Gavin at 9 a. m., Sunday, March 31, 1940, in the library of the University Club of Milwaukee.

2. Roll Call

The following were present, constituting a quorum: Councilors Gavin, Pippin, Jegi, Bowen, Fitzgerald, Clark, Butler, Gramling, Lambert, Heidner, Christofferson, Johnson, Pechous; President Arveson; Past-president Rector; President-elect Sproule; Treasurer Sisk; Vice-speaker Kurten; Delegates to the American Medical Association Smith and Sargent; Secretary Crownhart; and Assistant Secretary Larson. Others present, including guests invited to participate in certain orders of business, were Drs. R. M. Carter, Green Bay; J. O. Dieterle, C. C. Schneider, L. D. Smith, Herman Schumm and W. P. Blount, Milwaukee, members of the Orthopedic Section; Chester Echols, Milwaukee, member of the board of directors of the Medical Society of Milwaukee County; G. H. Hansmann, Norbert Enzer and L. J. Van Hecke, Milwaukee, officers of the Wisconsin Society of Pathologists; L. V. Littig, Madison, R. F. Wilson, Beloit, and J. E. Habbe, Milwaukee, members of the Radiological Section; and Mr. Mac F. Cahal, Chicago, executive secretary, Inter-Society Committee for Radiology.

3. Approval of Minutes of January Meeting

Upon motion by Fitzgerald–Jegi, the minutes of the January meeting of the Council, as published in the March issue of the Wisconsin Medical Journal, were approved.

4. Committee on Industrial Health

The report of the Committee on Industrial Health was approved and ordered entered upon the minutes of the Council, which report confirmed recommendation to the Industrial Commission of Wisconsin of the following physicians from which may be chosen a given number to act in an advisory capacity to the Commission in its pre-employment and periodic physical examination program: Drs. A. R. Tormey, Madison; Gunnar Gundersen, La Crosse; P. E. Oberbreckling, Milwaukee; O. A. Sander, Milwaukee, E. O. Gertenbach, Milwaukee; Millard Tufts, Milwaukee.

5. Status of Sections of the Society

The secretary was instructed to prepare a by-law to be presented to the Council at a later meeting specifically authorizing creation of "sections" of the Society and their status in the Society's determinations.

6. Membership

The secretary reported membership in the Society as of March 30, 1940, as 1,673 with dues paid for the year, which figure represented an increase of 125 members over the same date in 1937; 236 over 1938; and 267 over 1939.

7. Life Memberships

Dr. C. F. Browne, Racine, was recommended by the Racine County Medical Society as a candidate for life membership in the Society; his qualifications were discussed and upon motion by Pechous–Bowen, Dr. Browne was elected to life membership.

Dr. John J. McGovern, Milwaukee, a former president of the Society, was recommended for life membership by the Medical Society of Milwaukee County. Upon motion by Fitgerald–Butler, his election was confirmed.

8. Dues for Physicians Entering Membership in Year of Licensure

The secretary explained that, with the approval of the Executive Committee of the Council, he offered the suggestion that physicians entering the State Medical Society in the same calendar year of licensure have their state dues waived for that year, county society dues to be paid in accordance with custom. There was discussion by Councilors Butler, Jegi, Gavin and Gramling, President Arveson, Past-president Rector, and Secretary Crownhart. Upon motion by Butler–Jegi, the secretary was authorized to draft a by-law for consideration of the House of Delegates.

9. Delegate to U. S. Pharmacopeial Convention

Secretary Crownhart explained that Dr. Harry Beckman had been approved by the State Medical Society as delegate to the U. S. Pharmacopeial Convention in Washington in May, representing the State Medical Society as well as Marquette University; that the Convention officials had notified the secretary that dual representation by one delegate was not permissible; that a resident of Washington, D. C., could be appointed to represent the State Medical Society if it so chose. Upon suggestion of the secretary, and motion of Jegi–Butler, the secretary was authorized to invite Mr. Theodore Wiprud, executive secretary of the Medical Society of the District of Columbia, to represent the State Medical Society of Wisconsin.

10. Columns in Daily Press Covering "Hospital Notes"

Secretary Crownhart mentioned the growing practice of publishing personal items in the daily press, in columns delegated to that purpose, covering individuals in hospitals, designating their illness, etc. There was discussion by Councilors Gavin, Clark, Butler, Pechous, Jegi, President Arveson, Past-president Rector and Secretary Crownhart. Secretary Crownhart was instructed, without motion, to submit the question of possible violation of confidential relationships, as involved in this matter, to legal counsel, and to present a further report at the next meeting of the Council.

11. Rotation of Orthopedists in Conducting Clinics

Secretary Crownhart discussed the statement submitted by the Section on Orthopedics to the Council, and its adoption at the January meeting, as well as subsequent dissatisfaction resulting from the operation of the field clinics by rotation of the participating orthopedists. Several members of the Section on Orthopedics had been invited to the meeting, who discussed the problems involved; these included Drs. R. M. Carter, Green Bay; J. O. Dieterle, C. C. Schneider, L. D. Smith, Herman Schumm and W. P. Blount, Milwaukee. There was further discussion by President Arveson, Councilors Fitzgerald, Butler, Heidner, Pechous, Bowen and Clark; Past-president Rector, Secretary Crownhart and Assistant Secretary Larson. Upon motion by Christofferson–Heidner, the following procedure was adopted, to prevail in the future in conduction of the orthopedic clinics: In communities where a definite choice of orthopedist is made, that choice shall be respected; in communities where no choice is made, the orthopedist shall be selected from a rotating list; all considerations subject to the limitation of each orthopedist to two clinics per year.

Upon motion by Rector–Lambert, the subject matter was then referred to the Advisory Committee on Care of Crippled Children for consideration as to methods for eliminating the "repeat" cases in the field clinics, and those cases which overload the clinics each time they are held and yet are of a type which definitely do not belong there. The motion carried with it the recommendation that a report be carried to the general practitioners through the county medical society, as well as the orthopedists, to aid in weeding out the undesirable cases.

12. Osteopathic Propaganda

There was a discussion of the present trend of osteopathic thought and effort in the medical field, participated in by Secretary Crownhart, Past-president Rector, Councilors Bowen, Jegi, Gramling, Christofferson and Butler, and President Arveson.

13. Executive session

The Council resolved itself in executive session at 11 a. m. to consider various petitions from component societies. A recess was taken for lunch at 12:20 p. m. and the session was resumed at 1:45 p. m.

Upon rising from executive session at 2:20 p. m., the secretary was instructed to advise Drs. Ralph P. Sproule, J. Gurney Taylor and Francis D. Murphy, all of Milwaukee, that they had been constituted a special committee of the Council; to advise them of the Council position in the matter referred to them, and to ask that the Committee report to the Council as soon as possible, but not later than June next.

14. Advertising Standards for the Wisconsin Medical Journal

Secretary Crownhart discussed present advertising standards of the JOURNAL and asked the wishes of the Council in the future relative to accepting advertising from various sources. There was discussion by Councilors Gavin, Butler, Fitzgerald, Lambert, Bowen, Gramling, President Arveson, Past-president Rector, President-elect Sproule, and Secretary Crownhart. Councilor Butler moved that certain previously banned advertising be accepted; there was no second. Councilor Bowen moved non-acceptance of such advertising; there was no second.

It was moved by Butler–Jegi that the Executive Committee of the Council be empowered to act in an advisory capacity to the secretary in the matter of ruling on questionable advertising for the Journal. President-elect Sproule amended the motion to permit acceptance of beer and light wines advertising for a period of two years. The amendment was seconded by Councilor Jegi. The motion, as amended, was carried unanimously.

15. Recognition for Fifty Years of Medical Practice

Secretary Crownhart discussed recognition given in Illinois for fifty years of practice, and asked the wishes of the Council as to whether this subject might be explored further for Wisconsin physicians. There was discussion by Councilors Gavin, Clark and Butler, President-elect Sproule and Secretary Crownhart.

It was moved by Gramling–Butler that the chairman of the Council and the secretary be authorized to investigate the matter and report further at the next meeting of the Council, and with a view to establishing the time limit at forty years instead of fifty years of service.

16. Optometry and Infringement Upon Medical Practice

Two Milwaukee attorneys, Mr. George H. Likert, Jr., and Mr. F. N. Weidner, having previously secured permission, appeared briefly before the Council and discussed the implications in a case now pending involving the alleged practice of medicine by optometrists employed by department stores, citing that a Milwaukee circuit judge had ruled optometry to be a "learned profession," and inviting the State Medical Society to appear in the present case, or file briefs, in an "amicus curiae" status. There was brief discussion after their withdrawal from the meeting room. The subject was referred to legal counsel for study.

17. Miscellaneous

(a) Secretary Crownhart briefly discussed the matter of having been offered time on a recently organized radio chain in Wisconsin and the reasons for necessity of declining, but endeavoring to hold the opportunity open to permit future acceptance if circumstances permit at some later date.

(b) Councilor Bowen extended a cordial invitation to all members of the Society to attend the Watertown Graduate Clinic on April 25, and asked the cooperation of Council members in securing registrations from county society members in their sections of the State.

(c) Secretary Crownhart stated that the matter of surgical rates in commercial insurance contracts will be referred to the Wisconsin Delegates to the American Medical Association.

The meeting adjourned at 3:20 p. m.

J. G. Crownhart,
Secretary.

Approved:
S. E. Gavin, M.D.,
Chairman of the Council.

The Care of the Patient*

By DONALD GUTHRIE, M. D.†
Sayre, Pa.

IT IS indeed an honor to be invited by the Faculty of the Harvard Medical School to address the student body on some phase of the care of the patient—a very great honor, in fact, when one considers that this has been an annual event for the past twelve years and that some very outstanding men in medicine have been invited to deliver this lecture. It is also a satisfaction to be able to discuss the care of the patient rather than his treatment, for it implies that one is interested in the patient's welfare as well as in his disease.

I wish to congratulate you on the wisdom you have displayed in choosing the Harvard Medical School in which to study, for this school holds a very enviable position among the fine schools of this country; in fact, Embree, in his review in 1935 for the Rosenthal Fund of America's greatest universities, placed Harvard first among the five foremost universities. And to be in Old Boston, which offers so much that is cultural and inspiring, with its fine medical tradition built over the years by outstanding clinicians and surgeons who have worked and taught in this time-honored institution, is an advantage.

In spite of the great advances in medicine in the last twenty years and the contributions which our profession has made in disease prevention, disease control and the prolongation of life, it is distressing to be told —and I have been informed on good authority—that about 13 per cent of the population, or nearly 15,000,000 persons, have been weaned away from the medical profession. Among them, unfortunately, are the educated who have become faddists, those who have embraced Christian Science or faith healing and those who belong to the antivivisectionists and antivaccinationists. This last group, however, are often on the

* Lecture on "The Care of the Patient," presented at the Harvard Medical School, February 9, 1939. Reprinted from the New England Journal of Medicine 221: 679–682 (Nov. 2) 1939.

† Surgeon-in-chief, Guthrie Clinic, and Robert Packer Hospital, Sayre, Pa.

fence in their sympathies with our efforts as a profession. Then comes a group of less intelligent people who employ the cults—the osteopaths, chiropractors and naturopaths; and below this group in the matter of intelligence are the patent-medicine addicts, the victims of the quacks and a group of non-thinking persons who are just against doctors anyway. It will be difficult to reduce materially the numbers of the above-mentioned groups, but I firmly believe that by better treatment or better care or by education this, in some measure, can be accomplished.

There is another group, however, who are not sympathetic with our work or our efforts because of disappointment suffered at our hands, those who cannot understand that certain diseases cannot be cured, those who have been disappointed over the outcome of certain forms of treatment or operations, those who have been hurt and wounded by too much science and too little art, as modern medicine, unfortunately, is sometimes practiced today. This includes also a large number of people who break down today in merely trying to exist in our complex modern world, and who are considered too often in a scientific light when what they need most of all is understanding and help with distressing problems in life which are often the true underlying cause of their ill health. This is an ever-enlarging group of people, and it is most important that the modern physician become skilled in their management.

It is about this last-mentioned group that I wish to speak, for I believe that if our technic in approaching and treating these people could be improved, we could salvage great numbers of them and retain their sympathetic understanding of our efforts in their behalf, instead of having them give themselves into the hands of the cultists and other charlatans.

It would be wrong, of course, to advocate less science in the teaching of modern medicine; it would be iconoclastic to advise that less interest be placed on problems of research or that there be less emphasis on the teaching of the specialties, for we know too little about so much, and there are still great discoveries and advances which must be made, and which will continue to be made yearly. But I wonder oftentimes whether the student's training in the art of medicine is not being minimized, or at times neglected, because the science of medicine has become so intriguing and so fascinating—and the time is so short in which to review it all.

Here at Harvard you are fortunate in having professors who fully appreciate this situation, for here the true art of medicine is practiced and preached, and they feel so keenly about its importance that they have instituted these yearly lectures on the care of the patient.

I should like to review with you some of the influences which might be termed controllable and which keep large groups of people out of sympathy with our efforts for their welfare. In modern hospital and clinic work it is becoming increasingly more difficult to practice the art of medicine. The busy routine of an institution does not lend itself readily to a painstaking and broad consideration of the patient as an individual as well as of his disease. It is time-consuming to listen to a long story about home situations which at the time seem irrelevant, but often it is during the recitation of such homely things that the true cause of the illness under discussion is discovered.

It is in the busy life of a large institution that the young doctor may unconsciously acquire habits which will militate against his future success. The hurried, businesslike, serious approach to the patient—the thorough, systematic, orderly, quick but frigid first examination of some frightened, diffident patient—may give that patient an unfortunate impression of the institution and of its doctors. I was once an assistant of a famous surgeon who said he never wanted, as an assistant, a man trained in a near-by large city hospital, for while these men had had excellent training, there was a brusqueness, a roughness and a callousness about them that was very unfortunate. As he expressed it, the first encounter between the patient and the young doctor was "down with the bedclothes and up with the nightshirt" and a prompt and a fixed interest on the patient's diseased gall bladder rather

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than an interest in the patient who was unfortunate enough to have a diseased gall bladder.

I remember attending lectures in a city after I had finished my medical course, and of hearing the clinical professor of medicine, in a loud, booming voice, admonish his students with this caution: "Remember that the first duty of the physician is to search for and find the underlying pathologic process"—which he invariably tried to do with some quivering, terror-stricken patient shown before the class. This man was a great teacher, but I was informed that he had an extremely difficult time in making a living. As a true scientist there was no one better, but he represented a type seen often, one who has much learning but very little wisdom.

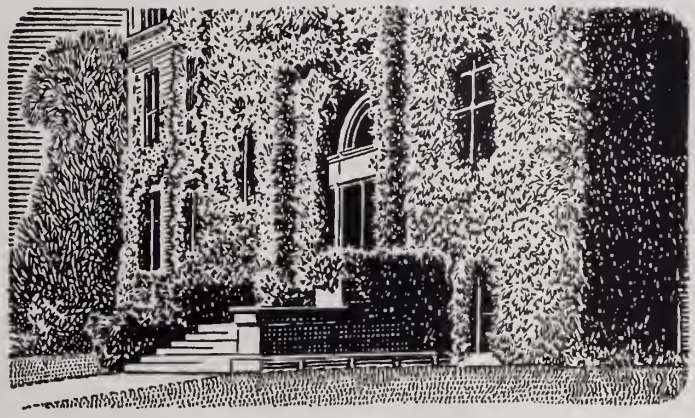
In regard to the initial approach to our patients: it is well to remember that they are all frightened, all apprehensive and many of them hypersensitive. It behooves every young man to develop a finesse in dealing with these people. It takes a certain personality to succeed in any walk of life. Many have it by natural inheritance, and others may acquire it by studying the ways of successful men and by developing within themselves those characteristics which make life a success; but, unfortunately, a few never can acquire the right type of personality which is so essential to success.

The student, the intern and every young physician should study the ways of his teachers, for invariably the successful teacher is a man of broad understanding and vision, a kindly man who is gentle and considerate with all his patients irrespective of their walks in life. I am grateful to my chiefs for teaching me many things which could not be learned in the operating rooms and in the laboratories, and I value my association with them while on rounds in the wards, in ward classes and in their consultation rooms, for there they dealt with human beings and not with unconscious patients or with laboratory problems.

As I have mentioned, functional disease is widespread and is increasing at a rapid rate. The present economic situation with its insecurity of the future is more than many of the population can withstand. We must remember that nearly all our patients having organic disease are mentally disturbed at the time of the first examination, and because of this it is of very great importance; but it is the patient who is functionally ill and with some organic lesion who demands a nicety of judgment to decide whether it is wise or best to concentrate our efforts alone on the organic lesion, to advise operation for the lesion or to treat the patient in a broad, general way, if there is no danger in delay. Many patients are accepted for operation in good faith and are thought to be well after the wound has healed per priman. They are listed as cured and return home to the troubled environment which may have been largely responsible for the illness. They then present a problem to the family physician and often to a psychiatrist, who may have reason to doubt the efficacy of the cure.

The anxious mother who is harassed by worries about her children or her husband and who has a retroverted uterus should not be accepted for operation without carefully weighing all sides of the evidence; the young man with a duodenal ulcer whose symptoms are all exaggerated by an increase of emotional strain had better be treated by any method other than operation. On the medical service the head of a family with a heart lesion, whose nights are veritable nightmares because of economic situations and hardships which will arise should his job be lost because of his lesion, needs understanding of his problems as well as digitalis; the mother who is crushed with grief over the death of a child had better not be accepted for operation without a most careful consideration of just how much effect her grief may have on her health. These are just a few of the problems which we see almost daily in our work, but each illustrates the importance of considering the patient as an individual as well as his disease. Ill-advised medical or surgical treatment of these patients is almost sure to be fraught with disappointment to the patient and to the doctor, and is one of the causes of having groups of people lose sympathy with our efforts.

The work of your great Cannon proves the harmful effect of emotions on bodily physi-



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ology. Would that its importance were more generally understood by our profession! The disastrous effect of fear is not fully appreciated. Long-continued anxiety, apprehension, doubt and fear will undermine the nervous equilibrium of even normal, healthy people.

The offspring of wild animals at birth are without fear, but that instinct needs only a few days of mother training to be developed to a high degree. Unhappy is the lot of any wild thing which loses its mother during the first few days of life, for without the fear instinct developed, it soon falls an easy prey to its many enemies.

Fear, therefore, as a means of protection has been of untold advantage to all species in their development, especially to man, who survived not only, perhaps, because he was fit, but because he knew when to retire and live to fight another time.

This instinct of self-preservation to flee from danger and to avoid painful contact, coming down to man through the ages, calls forth immense emotional activity. The thought or memory of an escape from an attack may cause the greatest degree of emotional excitement; so also the apprehending of an oncoming encounter with foe—or surgeon—may produce the same state of mind, and even though the individual remains passive during it, his exhaustion will be more complete and more profound than if he had given vent to his emotions in some form of motor activity. It is a well-known fact that fear associated with pain may exhaust the organism to the point of death. Our surgical patients whose minds are racked with these emotions of fear and worry are often exhausted before they are anesthetized, and are fit subjects for surgical shock. In no other disease is the relation between fear and the severity and aggravation of symptoms better shown than in exophthalmic goiter. The reduction in the operative mortality in the treatment of this disease has not been due alone to improvements in technic. It has come about since we have gained a better understanding of the disease and of the harmful effects of fright on these patients. Crile's great work on anoci-association is a monument to his splendid genius!

Cannon has shown that all bodily functions are altered and perverted by the emotions of pain, hunger, fear and rage—fear and rage being the most harmful. The preoperative rise in temperature, the fast pulse, the tremor, the insomnia and at times the glycosuria are the results of terror which grip the mind of the patient about to be operated on; oftentimes the subnormal temperature, the lost appetite, the drawn face and the languor seen in the postoperative patient are caused by grave worry and doubt. It is surprising to see the improvement in these patients as their mental attitudes are changed by suggestion.

Psychoanalysis reveals that much hysteria and psychoneurosis and many neurasthenic states have as their origin some past emotional upset—usually attended by fear or fright. We are all familiar with cases showing hysterical paralysis, aphonia, aphasia or blindness which can be definitely traced back to some terrifying emotion.

Granted, then, that fear is a harmful emotion which may be the foundation of future mental illness that upsets bodily economy, retards convalescence, interrupts recoveries and when severe and associated with pain may cause death, is not an earnest effort on our part to eliminate this emotion from our patient's mind justifiable? What may we do in a practical way to eliminate it? In the first place, the patient should be considered from a psychological standpoint from the time he is admitted until after he leaves the institution. During his entire stay his mental welfare and comfort must receive the same careful consideration as does his physi-

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cal welfare—for the majority of our patients are mentally as well as physically ill.

The personnel of the hospital should be chosen with great care, and the personality of each worker must suit the position he is to fill. Few of us realize how timid and diffident most of our patients are on admission, or how easily they may be hurt by apparent inattention, or frightened by their new surroundings. It is so important to have their reception a cordial and a friendly one, for the first impressions they get of the hospital and of us are often lasting ones. And this is as equally true of the general practitioner's work in his office and in the home as it is of the hospital.

Great benefit may be had by the proper treatment of those who are ill from emotional causes. We all know the importance of a careful examination followed by the proper kind of suggestion. Many of these people, while not suspicious, are keen, and they are disarmed and lose confidence promptly if they sense any uncertainty in the mind of the physician as to the exact cause of their illness. For this reason I believe a discussion of the patient's case with associates in the presence of the patient is most unfortunate, especially should there be an uncertainty as to the correct diagnosis. The chiropractor or the quack never shows that he entertains the slightest doubt as to the correctness of his diagnosis, and what benefit his patients show comes entirely from suggestion.

In closing, let me emphasize another very important point in the care of the patient; that is, our patients should not be allowed to suffer unnecessarily during illness, after injury or after surgical operations, nor should they be hurt by painful dressings or manipulations which may be necessary. The apprehensive patient who is allowed to suffer without need cannot be convinced that his condition is satisfactory—it is far from being so to him and he fears an unsatisfactory or fatal outcome. It is important to use light gas anesthesia or short intravenous anesthesia for painful dressings, for *brisement forcé,* for certain cystoscopic examinations or for the removal of gauze drains. We are

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not handicapped as were the older surgeons, who, because there were no anesthetics except ether and chloroform, were obliged to hurt their patients, at times severely. These men were forced to excuse their acts by the statement, "I am hurting you now to help you later." The modern operator should not hurt his patients or allow them to suffer unnecessarily—the modern surgeon will not.

Broadly reviewing the question of the care of the patient as one who has spent his entire professional life in clinic and hospital practice, I believe that as physicians we cannot rely on our skill alone for our full measure of success, for it is necessary for us to give ourselves freely to our patients at all times. They need to be comforted, assured and bolstered up during illness and for the trying ordeals they may have to undergo. Our optimism must be constant, and we should be trained in practical psychology if our patients' minds are to be freed from the harmful emotions I have described.

Little touches of human kindness, strict and constant attention to the patient's mental welfare, will do much to rob our clinics and our hospitals of their cold, institutional atmosphere, which frightens so many of our diffident patients and interferes with many a satisfactory recovery—and equally important, such a plan will not only keep many of our patients loyal to our profession but will win back to our fold many who have deserted us for the cults.

The Journal Bookshelf

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Compendium of Regional Diagnosis in Lesions of the Brain and Spinal Cord. By Robert Bing, professor of neurology, University of Basel Switzerland. Translated and edited by Webb Haymaker, assistant clinical professor of neurology and lecturer in neuro-anatomy, University of California. Ed. 11. Cloth. Price, $5. Pp. 292 with 125 illustrations, 27 in color and 7 plates. St. Louis: The C. V. Mosby Company, 1940.

Mosby presents a welcome companion volume to the recent addition of Bing's Text-book of Nervous Diseases. "Bing's Compendium," long out of print, is well known to older students of neurology. Bing and Haymaker are to be commended for again making available this valuable aid to students and others interested in neurological localization. Noteworthy is the excellence of the format to which the generous use of unusually clear and striking illustrations has contributed immeasurably. M. G. M.

Injuries of the Skull, Brain and Spinal Cord. Edited by Samuel Brock, New York University. Cloth. Price, $7. Pp. 632, illustrated. Baltimore: Williams & Wilkins Company, 1940.

This book, written by twenty-two (American–British) well-known specialists in their respective fields of neurology, neurosurgery, and psychiatry, endeavors to describe in detail—in one volume under the editorship of Samuel Brock—all of the immediate and remote effects of physical injury to the skull, brain, and spinal cord, together with their treatment and their medicolegal aspects. Needless to say, the gigantic task of condensing such a vast subject with its complicated ramifications, its controversial medical viewpoints, and its nonuniformity of therapeutic measures is fulfilled quite satisfactorily for the specialist, very instructively for the physician at large, and most informatively for the general practitioner, the medical student, and for the legal profession. Each chapter is appended by ample literary references, which fact facilitates a more profound study of the problems.

The nomenclature for the various states of injury is defined to its proper meaning but, the text states, "inexact and widespread usage is hard to change;" phrases such as chronic postconcussion state (syndrome), traumatic neurosis—hysteria—psychoneurosis—psychosis, post-traumatic personality disorders—convulsive states—malingering, are used all too readily by inexperienced physicians. A sound warning of diagnostic accuracy to the profession, with most instructive basic and statistical information is covered excellently in various chapters. The information given permits the reconstruction of all possible clinical events in a given case in the various chapters, whether they be purely physical or neurotic in the compensation phase. All modern therapeutic procedures are given sufficient space to permit the reader an evaluation of these tests.

The one volume dictionary "Injury of Skull, Brain and Spinal Cord" is recommended wholeheartedly to the medical profession because of its informative, detailed description of clinical states and effects from trauma, because of its wide range of therapeutic procedures, and the clear-cut definition of the medicolegal aspects. H. H. R.

Cancer of the Larynx. By Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S., honorary professor of broncho-esophagology and consultant in broncho-esophagologic research, Temple University Medical School, Philadelphia, and Chevalier L. Jackson, A.B., M.D., M.Sc. (Med.), F.A.C.S., professor of broncho-esophagology, Temple University Medical School, Philadelphia. Cloth. Price, $8. Pp. 309 with 189 illustrations and 5 color plates. Philadelphia: W. B. Saunders Company, 1939.

This is a well planned, excellently written, and profusely illustrated presentation of the subject. It is complete enough for the specialist, including all the various aspects of the disease and the surgical procedures used in its treatment. It is easily read and can be enjoyed and understood readily by the general man. The book maintains the high reputation set by other Jackson works. E. G. S.

Trapping the Common Cold. By George S. Foster, M.D., Manchester, N. H. Cloth. Price, $1.25. Pp. 125. New York: Fleming H. Revell Company, 1940.

This is a short book in which the author makes a plea for more hygienic living as a means for prevention of the common cold. He devotes practically the entire book to an outline of a hygienic day, including a discussion of sleep, diet, exercise, clothing, etc. The book is written for the layman. It offers nothing which could not be found in our former hygiene books but it has the advantage of being written in a concise form with interpretations in relation to the common cold. R. C. F.

The Newer Nutrition in Pediatric Practice. By I. Newton Kugelmass, B.S., M.A., M.D., Ph.D., Sc.D., attending pediatrician, Broad Street Hospital and Heckscher Institute, New York; consulting pediatrician, Lynn Memorial Hospital, Monmouth Memorial Hospital and Muhlenberg Hospital, New Jersey. Cloth. Price, $10. Pp. 1155, with 183 illustrations. Philadelphia: J. B. Lippincott Company, 1940.

This book is an excellent guide for the general practitioner or the pediatrician who is primarily concerned with the normal growth and development of children. It is well organized and very readable.

The text is divided into three main sections. The first deals with the physiology of nutrition in all of its aspects. The second section discusses nutrition in health from the newborn period through infancy, the preschool age and childhood. Section three is devoted to a very complete discussion of the nutritional aspects of the deficiency, metabolic, allergic, infectious and regional diseases. The last two sections are especially practical, for the author includes various formulas and diets of proven worth in health and those which have been found most successful in nutritional diseases.

The author has drawn much from his own broad experimental and clinical experience, but the text includes many references from the best and latest literature in the field of nutrition. K. B. McD.

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*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Sheianski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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COMMENTS ON TREATMENT

Peterman—Treatment of Convulsions

(Continued from page 375)

determinations made. I have never seen a convulsion or repeated true convulsions which were due to a low blood sugar. I have seen seven patients in whom the convulsive state was attributed to hypoglycemia but in none could I verify the diagnosis. I have seen children with attacks of weakness, dizziness or fainting associated with low blood sugars, which were relieved by the administration of sugar, but in no true convulsive state was this finding confirmed.

There is a difference of opinion concerning the value of a spinal puncture in the convulsive state. I have found too many cases of unsuspected encephalitis, meningitis, and cerebrospinal syphilis on examination of the spinal fluid to dispense with this useful and harmless procedure. Certainly no neurologic case is completely studied without a spinal fluid examination. There are certain cases of mild or of sterile meningitis which are completely relieved with one drainage of spinal fluid. Unless a brain tumor is suspected, there is no contraindication to spinal puncture.

Intracranial hemorrhage in the newborn infant cannot be positively diagnosed without the finding of blood in the spinal fluid. If the blood is in the subarachnoid space it is better to drain off the bloody fluid than to allow it to clot or to be absorbed. In subdural hematoma the diagnosis may be substantiated and the convulsions temporarily relieved by aspiration of the blood from the subdural space.

When convulsions are due to intracranial injury, such as skull fracture or contusion, the treatment depends on many factors and generalizations cannot be made.

Never give opium in any form for convulsions.—M. G. PETERMAN, M.D., Milwaukee.

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PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

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Guttmann, E. and Sargant, W.: **Observations on Benzedrine**—Brit. Med. J., 1:1013, May 15, 1937.

Nathanson, M. H.: **The Central Action of Beta-aminopropylbenzene (Benzedrine)**—J.A.M.A., 108:528, Feb. 13, 1937.

Myerson, A.: **Effect of Benzedrine Sulfate on Mood and Fatigue in Normal and in Neurotic Persons**—Arch. Neurol. & Psychiat., 36:816, Oct., 1936.

Wilbur, D. L.; MacLean, A. R. and Allen, E. V.: **Clinical Observations on the Effects of Benzedrine Sulphate**—Proc. Staff Meet. Mayo Clin., 12:97, Feb. 17, 1937.

Woolley, L. F.: **The Clinical Effects of Benzedrine Sulphate in Mental Patients with Retarded Activity**—Psychiatric Quart., 12:66, January, 1938.

Davidoff, E. and Reifenstein, E. C., Jr.: **The Stimulating Action of Benzedrine Sulfate**—J.A.M.A., 108:1770, May 22, 1937.

Guttmann, E.: **The Effect of Benzedrine on Depressive States**—J. Ment. Sci., 82:618, Sept., 1936.

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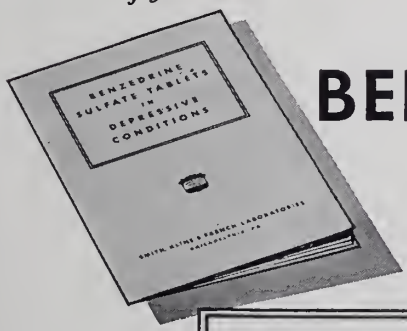

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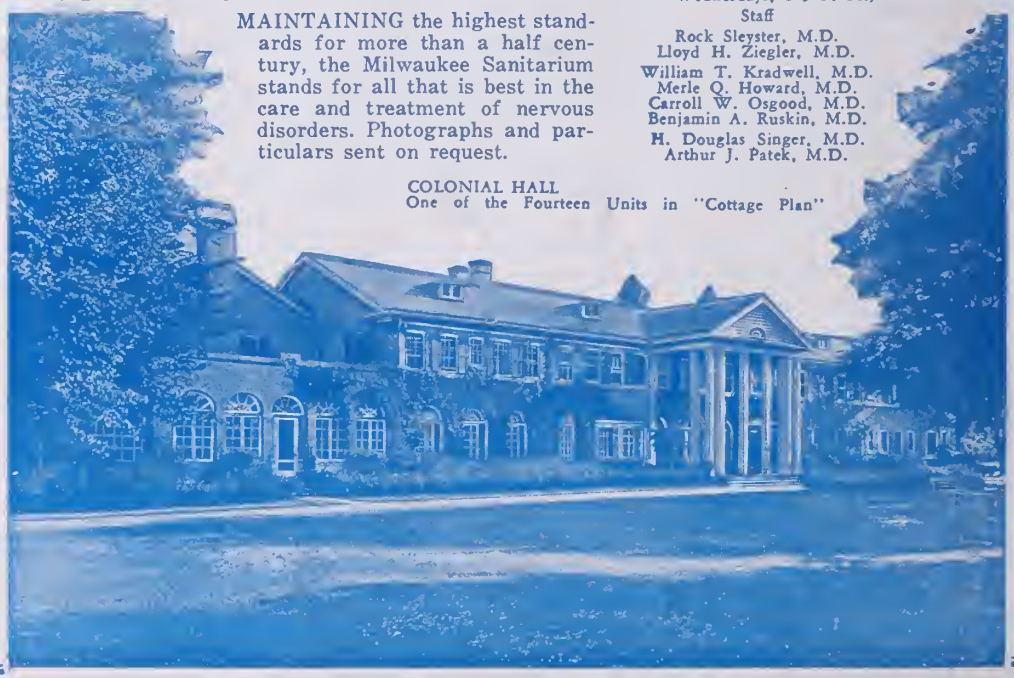

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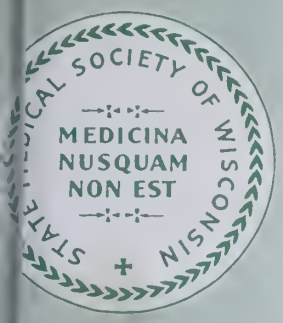

The Wisconsin Medical Journal

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By Eben J. Carey, M. D.
G. H. Coleman, M D.
Harry Culver, M. D.
Eugene Cary, M. D.
E. W. Ryerson, M. D.

AVIATION MEDICINE
By A. W. Hankwitz, M. D.

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XXXIX, Number 6
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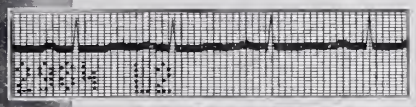
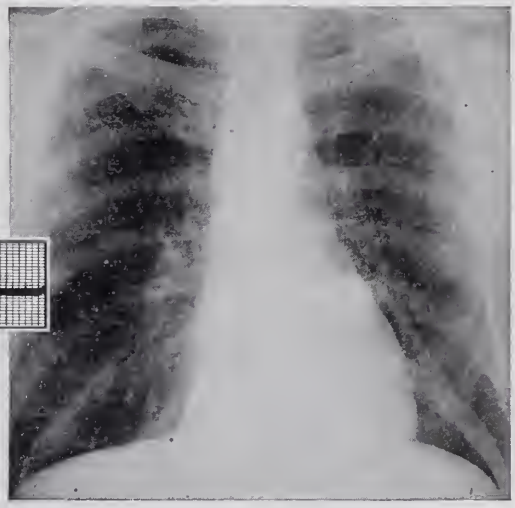
STUDIES IN THE AVITAMINOSES

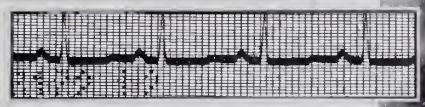
This page is the sixth of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the May 25 issue of The Journal of the American Medical Association.

Teleoroentgenogram, at left, of alcoholic patient with severe thiamin deficiency, marked cardiac dilatation, congestive heart failure. X-ray below, taken after three weeks of thiamin chloride therapy, shows marked reduction in cardiac size. Patient received no digitalis.



Electrocardiogram on admission (Lead 2). Note the low voltage of the QRS complexes and of P and T waves. (Left)





After three weeks of thiamin chloride therapy. Note increased voltage, return of P waves. Later tracings showed normal T waves. (Lead 2)

Courtesy of Henry Field, Jr., M.D., University of Michigan.

The Cardiac Manifestations of Vitamin B_1 Deficiency

Vitamin B_1 apparently exerts no specific influence upon the normal heart, but profound deficiency resulting from drastic deprivation may lead to cardiac derangements which are as characteristic as the neural changes at times resulting from thiamin deprivation. In the cases reported, physical examination disclosed that the heart was enlarged to both the right and the left, although on postmortem examination of patients who died of extreme deficiency the enlargement was seen predominantly in the right auricle and ventricle. The former was dilated and paper thin; the wall of the latter appeared thickened and its chamber enlarged. Some difference of opinion exists concerning the mechanism of the increase in cardiac size, since both hypertrophy and edema have been observed by different investigators.

The clinician, through whose courtesy the x-rays and electrocardiograms shown above are made available, states that administration of thiamin chloride promptly led to reduction in the cardiac silhouette.

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Volume XXXIX
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"The functions of minerals are so important that they may well be said to control life itself." (1)

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Earlier physiologists considered the following list of inorganic elements to be fairly complete as far as animal nutrition was concerned:

Calcium	Sodium	Phosphorus
Iron	Potassium	Chlorine
Iodine	Magnesium	Sulfur

However, copper, manganese, zinc, and apparently cobalt must now be added to this list of elements considered indispensable or desirable in nutrition. Also, analyses of animal tissues have disclosed the presence of the so-called "trace elements" (aluminum, silicon, arsenic, fluorine, bromine, barium, rubidium, nickel, and selenium). Which of these perform definite roles in mammalian metabolism and which are present as contaminants, future research alone can decide (2).

Although the specific functions of all the essential minerals may not be completely known, it is apparent that many of these inorganic elements—in the form of their salts or ions—are associated with vital body activities. Thus, the initiation and continuance of cardiac function, the maintenance of osmotic relationships of tissues and of the acid-alkaline balance, and the formation of bony and calcareous tissue and of hemoglobin are a few of the vital functions of the minerals (1). It should be evident that the above quotation is in no wise an overstatement of the importance of the minerals in nutrition.

As to their occurrence in nature, the minerals are rather widely distributed in foods, although the extent to which they may occur—even in the same food variety—is known to be variable (3). No one food or class of foods has been richly endowed with *all* the elements essential in nutrition. Consequently, to insure an optimal intake of minerals the diet should be planned to include—in so far as possible—all food classes.

In the preparation of foods for the table, attention should be given to preservation of their mineral values. Because of their water-soluble nature, certain minerals may be lost to the cooking water during food preparation. Therefore, to obtain the full mineral benefits of foods, the cooking water containing the extracted minerals should in some way be utilized.

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REFERENCES

(1) 1939. Mineral Metabolism, Alfred T. Shohl, Reinhold, New York.

(2) 1940. Nutrition Abstracts and Reviews 9, 515.

(3) 1938. Univ. Colorado Studies 25, 181.

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SUPPORT WITH BRACE FOR THE LOW BACK

Commenting on the increased likelihood of patients with spondylolisthesis lesions to suffer from industrial low back injury and on the pathology and symptoms of such injuries, an orthopedic surgeon* in a recent article continues, as follows: "... one begins by putting the patient to bed for anywhere from a few days to two weeks. Physiotherapy is used to give relief from pain and to strengthen the muscles of the back. Sometimes it is well to assure rest to the injured back by immobilization in a plaster jacket. When the patient gets out of bed one must provide him with a low back belt if the symptoms have been mild, or with a spinal brace if rigid support is needed. If, in spite of prolonged conservative treatment, the pain and weakness in the back and the disability continue, one must realize that permanent internal fixation is required."

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*Samuel Kleinberg, M.D.
New York State Journal of Medicine
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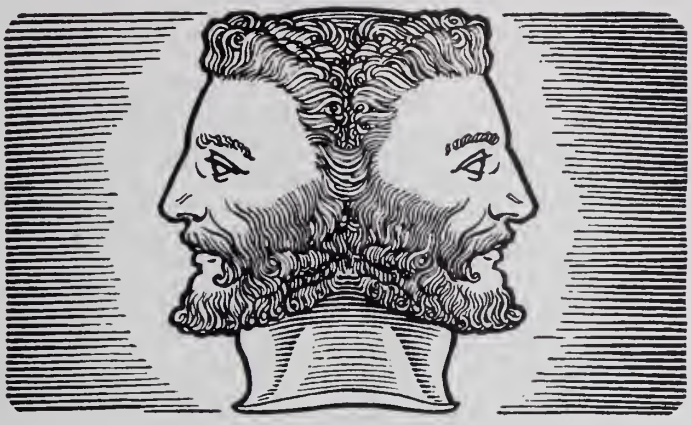

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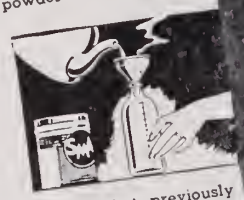

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*Low Back Pain; A Symposium**

1. Anatomical Aspect

By EBEN J. CAREY, M. D.†
Milwaukee

Introduction

THE anatomy of low back pain involves practically the structure of the entire living human body. For the purposes of this paper the anatomy and development of the spine and its topographic relations will be considered from a broad and not a detailed point of view.

The spinal column is an indicator of muscle-bone balance. A good indication of the complex mutual interrelationship of muscle, tendon, ligament, bone, joint, nerve and blood supply is a consideration of abnormal deviations and curvatures of the spine. These pathologic curvatures, demonstrated in the muscle-bone balance model of the spine, will emphasize the importance to the general practitioner of a knowledge of living human anatomy as a foundation for physical examinations and diagnosis of pain in the back.

In the past the anatomy of the back has been neglected by medical students. Since charlatans are most liable to promise relief in fields where medical knowledge is deficient it becomes an obligation on each practitioner to have knowledge of the anatomy underlying low back pain.

Anatomy of the Human Spine

The human spinal column is the central axis of the skeleton and is situated in the median line at the posterior aspect of the trunk. It is normally composed of thirty-three segments or vertebrae, twenty-four of which are true or movable and nine false or fixed vertebrae. Of the true vertebrae, the first seven are called cervical, the succeeding twelve, thoracic or dorsal, and the remaining five lumbar. Of the false vertebrae, the first five form one mass, called the sacrum, and at the terminal part of the column are three to five fused segments forming the coccyx.

The vertebral column functions as a pillar of support for the trunk and a case for protection of the spinal cord and nerve roots and meninges. Cephalad it supports the skull; laterally it gives attachments to the ribs, through which in part it receives the weight of the upper limbs; and caudad it is supported by the hip bones, by which the weight of the trunk is transmitted to the lower limbs. The structure of the whole column accords with the necessities of these functions, and thus the vertebrae of which it is composed show their individual agreement with the general arrangement of the whole: they are modified in details according to their position, but they are all built on the same general principle.

This principle may be illustrated, briefly, on a vertebra taken from the center of the column and used as an illustration of the positions of the chief parts of a "typical" vertebra. In front a strong *body* carries and transmits weight. It is the more fixed part of the column and to its dorsal aspect is attached the spinal cord. The attachment of the spinal cord to the more stable bodies prevents overstretching of the cord in flexion of the column. The *neural* arch behind the bodies encloses the spinal cord: in conformity with this we find the strong pads of inter-

* Presented at the 98th anniversary meeting, State Medical Society of Wisconsin, Milwaukee, September, 1939.

† Dean and professor of anatomy, Marquette University School of Medicine.

vertebral discs placed between the bodies of contiguous vertebrae, whereas, the arches are connected by ligaments and tend to overlap one another. The arch is relatively more movable than the bodies. In the articulated column the successive arches and ligaments, with the dorsal aspect of the bodies, enclose a spinal canal for the cord and meninges (pachymeninges and leptomeninges), and the portion of the canal that is enclosed in the neural arch of each separate segment is the spinal foramen of that vertebra. The neural arch has spinous, articular, transverse processes, as well as laminae and pedicles. No details of these structures are necessary in this paper.

The length of the spinal column varies in different skeletons, but on an average it measures about 70 cm. in the male and about 2.5 cm. less in the female. It constitutes about 45 per cent of the entire body length. To the entire length of the column the cervical region contributes about one-sixth, the thoracic about one-third, the lumbar about one-fourth, and the sacrococcygeal portion the remaining one-sixth. About one-fourth of the length of the presacral spine is made up of the intervertebral discs. The pathology of these discs is becoming more important as one cause of low back pain.

The length of the movable or free vertebral column (cervical, thoracic and lumbar) at the end of the second fetal month is about 2 cm.; in the third fetal month 4 cm.; at the end of the fourth 8 cm.; and at the end of the ninth fetal month 20 cm. in length. Between birth and maturity the movable vertebral column increases in length about 2.5 times; two-thirds of this growth is reached before puberty.

The ratio of the various segments of the vertebral column shifts with the chronologic and anatomic age of the individual. The cervical and sacral regions form the greater part of the column during the second and third fetal months. At birth the cervical part forms approximately one-fourth, the thoracic part one-half and the lumbar one-fourth of the movable vertebral column. By the third year the adult ratio is reached and this has been given above.

The striking characteristic of the complete articulated column when viewed as a whole is the presence of "curves." There are two sets of curves; the primary or accommodation curves and the secondary or compensation curves. There are four of these in the sagittal plane or profile view, convex forward in the cervical and lumbar regions, concave forward or ventrad in the dorsal and sacral zones. The dorsal curve is primary and may be looked on as the persisting curve of the embryonic axis. The sacral curve is also primary. These two primary curves are for the accommodation of the thoracic and pelvic viscera. The thoracic curve extends from the second to the twelfth dorsal vertebra, and the sacral curve coincides with the sacrum and the coccyx.

The secondary curves of compensation are found in the cervical and lumbar regions and have their convexities directed ventrad. They are curves that compensate for the assumption of the upright posture and are developed due to changes in the intervertebral discs. The cervical curve appears with the development of ventral flexion of the head on the chest at about the third postnatal month of the infant and with the sitting posture at about the sixth postnatal month. The curve is never consolidated or fixed in the vertebral column. It is present in the upright but obliterated with the horizontal posture.

The lumbar curve between the twelfth dorsal vertebra and promontory of the sacrum appears between the ninth and twelfth postnatal month when the child begins to stand and attempts to walk. This curve becomes consolidated in adult life.

The most anterior part of the cervical convexity is the front of the body of the fourth cervical vertebra, and the curve ends below at about the second dorsal vertebra: the body of the seventh or eighth dorsal vertebra usually forms the point of greatest posterior projection in the dorsal curve, which ends below between the twelfth dorsal and first lumbar vertebrae.

The fifth curve is lateral and is a secondary, compensation curve. It is in most cases directed to the right and is found in the upper thoracic or dorsal region. Its convexity, usually to the right, is probably asso-

ciated with the greater use of the right hand. It is modified by race and occupation. The common finding in the ventrodorsal view therefore is a physiologic right lateral scoliosis.

The primary curves of accommodation have associated direct changes in the bodies of the dorsal and sacral regions, whereas, the secondary or compensation curves have associated changes particularly in the discs. At about the third week of intra-uterine life the first primary curve appears with the snail-like coiling of the entire embryo. During this time the vertebral column has a pronounced ventral flexion. The uncoiling of the embryo occurs between the third and sixth week of intra-uterine life. The movable or free portion of the vertebral column gradually becomes straighter while the sacral portion first becomes straighter and later acquires a second ventral curve. In the newborn child the true or free column forms a single gentle curve with a ventral concavity extending from the first cervical to the last lumbar vertebra, while the sacrum and coccyx are directed somewhat dorsad.

In the female the sacrum is turned dorsad to a greater extent than in the male. This causes a more prominent lumbosacral angle, but it is modified by the lumbar curve becoming more pronounced; thus in women the fourth lumbar vertebra is usually more prominent than in men. If an anomalous sixth lumbar vertebra is present there is consequently a still greater tendency to spondylolisthesis, a forward gliding of the caudal surface of the fifth lumbar vertebra over the cephalic aspect of the first sacral vertebra.

The presence of the primary and secondary curves in the column or vertebral pillar above the sacrum adds to its elasticity while the number of curves gives it a greater resistance to weight than would be afforded by a single curve; weight is transmitted to the top of the sacrum and from thence to the innominate bones, so that the sacral curve is merely an adaptation to the contents of the pelvis not concerned in weight transmission, and differs in the sexes.

The aortic impression consists of a variable flattening of the left side of the dorsal vertebrae from the fourth to the tenth segment.

From the ventral aspect the bodies of the vertebral column present a series of pyramids due to the successive increase and decrease in the size of the bodies. They become wider from the axis to the first dorsal vertebra, then decrease to the fourth dorsal vertebra. The apex of the first pyramid is directed upward, and that of the second is directed downward. Their bases are in opposition. The third pyramid extends from the fourth thoracic to the fifth lumbar vertebra with its base caudad. The fourth pyramid includes the sacrum and coccyx with the base cephalad and the apex caudad.

In the lateral view, the intervertebral foramina appear oval in shape. These foramina increase in size progressively from cephalocaudad, being smallest in diameter in the cervical and largest in the lumbar region. The spinous processes of the second and seventh cervical, first thoracic and all the lumbar vertebrae are most prominent.

From the dorsal aspect the line of the spines shows frequent irregularities without any deviation in the line of the weight bearing bodies. On each side of the line of the spines the vertebral groove runs down the length of the column, floored by the laminae and backs of the articular and transverse processes: it is occupied by the deep and superficial layers of the postvertebral muscles.

Observe the spinous and transverse processes. The former project in the midline, and the latter as two lateral rows. The width of the transverse processes varies. They are more or less regular in the cervical region, but large in the first and last members of the series; their width decreases from above down in the dorsal vertebrae, and increases again in the lumbar region to the third or fourth vertebra.

Topographic Anatomy

There are certain vertebrae which are of special value to the physician, since they stand as landmarks to guide him to the seat of other parts of the body. Thus, the third cervical vertebra corresponds to the following parts: (1) the opening of the larynx, (2) the point of origin of both the external and

internal carotid arteries, (3) the situation of the superior cervical ganglion of the sympathetic nerve. The fifth cervical vertebra is a guide to the following parts: (1) the lower opening of the larynx, (2) the beginning of the trachea, (3) the lower end of the pharynx, (4) the upper opening of the esophagus, (5) the middle cervical ganglion of the sympathetic nerve. Finally the second lumbar vertebra corresponds to the following parts: (1) the termination of the duodenum, (2) the commencement of the jejunum, (3) the lower border of the pancreas, (4) the upper root of the mesentery, (5) the point of origin of the superior mesenteric artery, (6) the commencement of the thoracic duct, (7) the opening of the ductus communis choledochus into the intestine, (8) the commencement of the vena porta, (9) the termination of the spinal cord, (10) the point of origin of the cauda equina, (11) the attachment of the crura of the diaphragm, and (12) the situation of the receptaculum chyli.

In addition to these three vertebrae, which are of special value as guides to more than one part of the body, may be mentioned the seventh cervical vertebra whose long spine is a guide to the level of the apices of the lung in the male, since in the female it extends higher up; the third dorsal vertebra at the level of which the aorta reaches the spinal column, the trachea bifurcates and the apex of the lower lobe of the lung is found; the eighth dorsal vertebra which indicates the lower level of the heart and that of the central tendon of the diaphragm; the ninth dorsal vertebra at which level the upper edge of the spleen is found in health, and where also the esophagus and vena cava pass through the diaphragm; the tenth dorsal vertebra, which corresponds to the lower edge of the lung, the spot where the liver comes to the surface posteriorly, and the situation of the cardiac orifice of the stomach; the eleventh dorsal vertebra which is a guide to the normal situation of the lower border of the spleen, and to the upper part of the kidney; the twelfth dorsal vertebra which marks the lower limit of the pleura, the passage of the aorta through the diaphragm, and the situation of the pyloric end of the stomach; the first lumbar vertebra where the renal arteries are given off, and where the pelvis of the kidney may be found; the third lumbar vertebra which corresponds to the level of the umbilicus, and the lower border of the kidney; and, finally, the fourth lumbar vertebra which marks the point of bifurcation of the abdominal aorta into the two common iliac arteries and which lies on the level with the highest part of the ilium.

It may be of value to the physician in examining the chest or endeavoring to locate the exact situation of any particular point upon the chest to remember that the spine of the third dorsal vertebra is on the same level as the commencement of the spine of the scapula; that the spine of the seventh dorsal vertebra lies on a level with the inferior angle of that bone; and, finally, that the spine of the last dorsal vertebra is on the level with the head of the last rib, which may be used as a guide to certain surgical operations upon some of the abdominal viscera.

Between the different vertebrae are placed foramina through which the spinal nerves escape from the spinal canal to reach the parts which each is destined to supply. It is often useful to know the vertebrae opposite to which the nerves of any special region arise from the spinal cord, since the point of origin does not always correspond to the foramina of escape. The following guides may be furnished by the vertebrae, to locate the seat of lesions of the spinal cord, which are affecting any special nerves or set of nerves.

The interval between the occiput (inion) and the sixth cervical spine marks the limits of origin of the eight cervical nerves; that between the sixth cervical and the fourth dorsal spine marks the origin of the first six dorsal nerves. Between the eleventh and twelfth dorsal spines the five lumbar nerves arise as the upper part of the cauda equina; while the origin of the five sacral nerves corresponds to the single vertebra, the twelfth dorsal spine. It should be remembered that the spines of the vertebrae are not always in a precisely straight line but that in persons possessing the greatest strength, an occasional deviation of single vertebrae either to the right or the left may exist. It is by

knowing these natural variations that we can guard ourselves against error in diagnosis.

Physiology of the Spine

The curves of the vertebral column serve the following purposes: (1) they contribute to the wonderful strength of the spine sixteen times that of a straight one, since its curves are alternating; (2) they convert the spine into an elastic structure and thus afford a springy pillar upon which the head shall rest, rendering the danger of severe jarring of the brain a minimum one; (3) the curves are so arranged as to favor the lodgment of organs, since the cavity of the chest is greatly enlarged thereby, and the weight of these organs is still kept within the line of the center of gravity, a fact to be considered in the arrangement of muscles, as less power is required to preserve the proper balance; (4) the curves are so gradual as to prevent the possibility of compression of the spinal cord, which might occur were there any abrupt angles to the canal; (5) the curve of the cervical and dorsal regions adds greatly to the beauty of outline of the body, while the cervical curve facilitates the movements of the neck.

The curves of the vertebral column are due, in great measure, to the variations in thickness of the intervertebral fibrocartilages, but partly also to the relative thickness of the bodies of the vertebrae of the different regions, and to the tension exerted by the ligamenta subflava, which connect the laminae of the different vertebrae together.

The spinal column is capable of four types of movement, viz., flexion, extension, lateral and torsion. The first two are freest in the neck, least free in the dorsal region and less free in the loins than in the neck. This is largely due to the fact that the spines of the dorsal vertebrae overlap each other, particularly from the fourth to the eighth, and that the articular processes of the dorsal vertebrae are nearly perpendicular, so that movement is prevented; while, in the cervical region, the articular processes are oblique, the intervertebral discs thick, and the spinous processes of the third, fourth and fifth vertebrae are purposely made short and horizontal. The lumbar vertebrae have also thick intervertebral discs, which allow of movement between their spinous processes; and the articular processes are so placed as to allow of a limited movement. Flexion and extension of the spine are freest between the third and sixth cervical vertebrae, between the eleventh dorsal and second lumbar vertebrae, and again between the last lumbar vertebra and the sacrum. In cases of tetanus, or, in those feats of the acrobat where the body is made to rest upon the head and heels alone, this point is admirably shown. The lateral movements of the spine are very free in the neck, so as to allow of an easy carriage of the head, and in the loins so as to permit of movement of the trunk. The movement of rotation of the spine is confined almost exclusively to the lumbar region, and it is this power of movement that enables the head to be rotated beyond the ability of movement of the atlas upon the axis, through a participation of the trunk. Holden suggests an admirable way to demonstrate this point: "Sit upright, with your head and shoulders well applied to the back of the chair; the head and neck can be rotated to the extent of 70°. Lean forward, so as to let the lumbar vertebra come into play; you can then turn your head and neck 30° more."

The intervertebral discs are soft and of a pulpy consistence in the central portion, but firm at the edges and they thus tend to form a ball and socket joint which permits of a certain amount of movement in every direction between the vertebrae which they separate. By the weight of the body they are compressed, so that at night the height of an individual is often diminished some fraction of an inch from the measurement taken after a night's repose. A habit of leaning toward one side may make a permanent deformity by destroying the elasticity of these cartilages. Thus, a distortion of the spine may not always indicate disease.

Upon each side of the spines of the vertebrae may be perceived a deep groove for the strong muscles of the back. If we look at the spinal column from the front, we can perceive that the transverse processes of the atlas are very long, so that the muscles which rotate the head can gain additional leverage. An enlargement of the column can be de-

tected at the lower part of the cervical region, so as to form an expanded base for the neck, and a diminution in the width of the column can be detected in the dorsal region in order to afford more room for the lungs. A slight lateral curvature in the dorsal region may often be perceived, which is attributed by some authors to the excessive use of the right arm, since the concavity is usually toward the left side. This point should be remembered as a frequent and natural deformity when diagnosing a lateral curvature as the result of disease.

Along the entire length of the spinal column on its posterior aspect the spinous processes form a prominent bony ridge, which may be felt through the skin of the back even in the fattest people, and which is occasionally prominent during life. It will be noticed that the spine cannot be felt in the cervical as distinctly as in the dorsal and lumbar regions, for the following reasons: (1) on account of the curve, (2) on account of the attachment of an elastic ligament (the ligamentum nuchae) which extends from the head to the last cervical vertebrae and assists the muscles in supporting the head at a right angle to the spine, (3) from the fact that the spines of the third, fourth and fifth cervical vertebrae are made shorter than the rest so as to admit of free extension of the neck, (4) on account of the muscles which tend to render the long spine of the axis less prominent than it would be otherwise. In a muscular subject, the spines of the vertebrae of the dorsal and lumbar regions, instead of being prominent as they are in the skeleton lie in a median depression or groove, which extends the entire length of the back and is caused by the prominence of the erector spinae muscles upon either side of the spines.

The spinal canal which is enclosed by the vertebrae extends throughout the entire length of the spinal column and contains the spinal cord, and the lumbar, sacral and coccygeal nerves, after the spinal cord has terminated in the cauda equina. The vertebrae so overlap each other, posteriorly and at the sides, that it would be extremely difficult for any cutting instrument to injure the spinal cord, except between the occiput and the arch of the atlas, where animals are usually "pithed," and in the lumbar region where a cutting instrument might possibly injure the lumbar or sacral nerves. The spinal canal is larger in the neck and the lumbar region than in the dorsal, which fact is explained on two grounds: first, because there are two enlargements present on the spinal cord (where the large nerves of the upper and lower extremities arise), which demand increased space, and, second, because the dorsal region does not admit of much motion and therefore the spinal cord requires less room to insure its safety from pressure than in the neck or lumbar region, where the movements of the spinal column are more extensive.

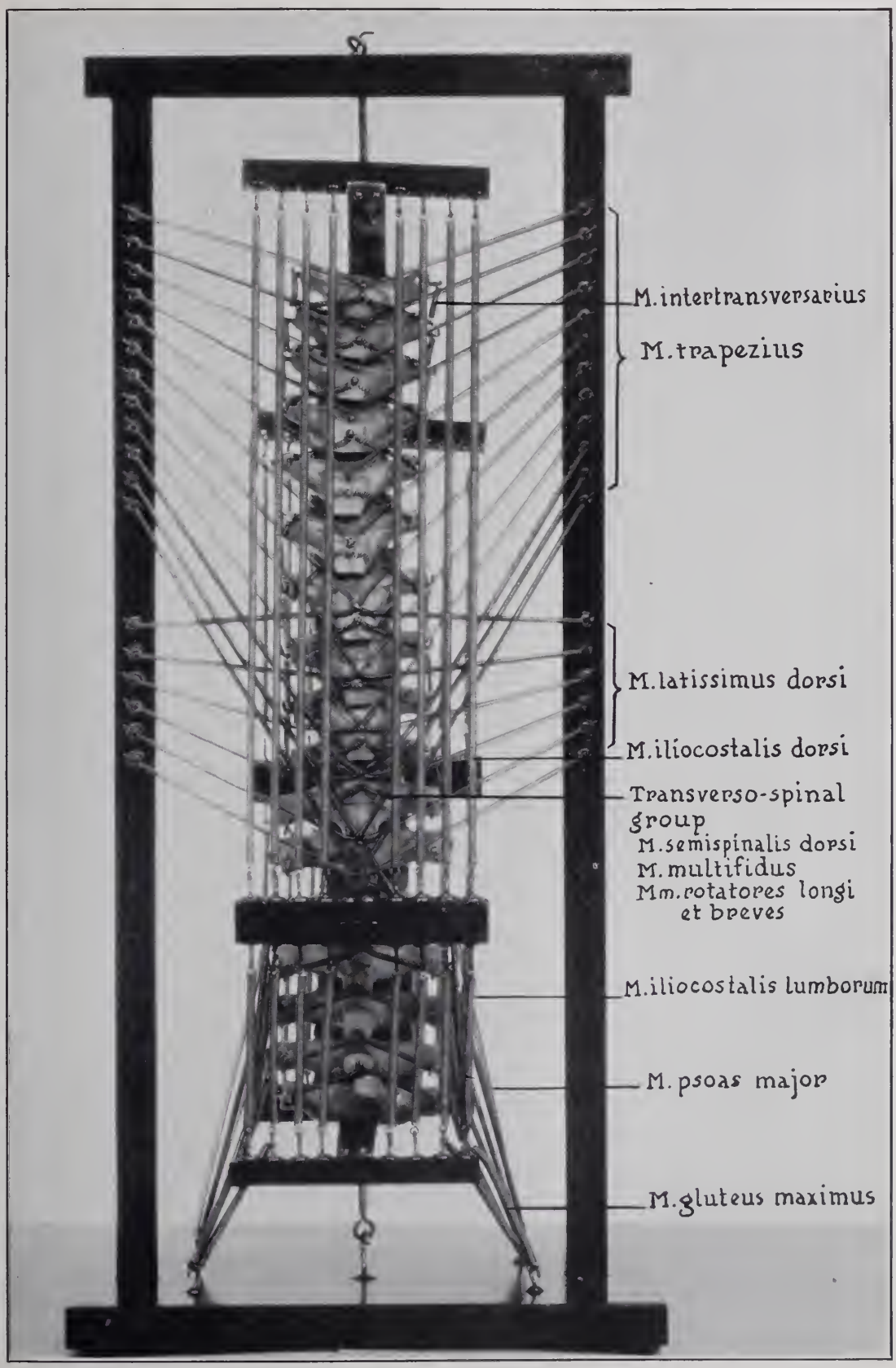
The vertebrae are so interlocked, by their spinous and articular processes, as to render the danger of dislocation of any bone extremely slight; in fact, such an accident would be impossible in the dorsal and lumbar regions without a fracture of the processes having first occurred. But, in the cervical region, such cases have been reported and specimens of the dislocation are shown in some of the large collections of osteological curiosities. Sudden and forcible rotation of the neck may be followed by such dislocation.

The excessive length of the transverse processes of the altas affords one of the many examples of the provision to increase the leverage of muscles and thus to add to their power, since the inferior oblique muscles of the neck are thus enabled to rotate the head with greater ease than if the transverse processes were of the same length as those of the other cervical vertebrae.

The transverse ligament, which serves to retain the odontoid process of the axis in close relation to the atlas, is an important

Fig. 1 →

Fig. 1.—Dorsal aspect of the dynamic muscle-bone balance model of the human spine (about one-fifth natural size). The spine has no direct solid support but is suspended in a field of bilaterally balanced tensions of steel wire springs. The twelve dorsal and five lumbar vertebrae are composed of oak wood and between the vertebrae are placed discs of felt which represent the intervertebral discs. Dorsad to the center of the vertebral bodies is a hole through which is threaded a wire spring one-fourth inch in diameter. This axial spring is attached above and below to the stand and permits mobilization of the vertebral bodies in relation to one another.


M. intertransversarius
M. trapezius
M. latissimus dorsi
M. iliocostalis dorsi
Transverso-spinal group
M. semispinalis dorsi
M. multifidus
Mm. rotatores longi et breves
M. iliocostalis lumborum
M. psoas major
M. gluteus maximus

structure, since it protects the medulla oblongata from the pressure which would otherwise be exerted upon it by that process of bone when the head is bent forward; hence, the fatal consequence of rupture of that ligament when hanging is scientifically performed upon a criminal. In spite of the strength of this ligament and the deep groove in the odontoid process in which it fits, it occasionally slips out of its place with fatal results to the patient. Such displacement is more liable to occur in the child than in the adult, since in a child the ligaments are weak and liable to be more relaxed. The odontoid process of the axis is much shorter in the child than in the adult and thus more readily allows the transverse ligament to slip over its apex.

The body, being the weight bearing part of the vertebra, is built to sustain this load. Elasticity is attained in the bodies of the vertebral column by the cancellous composition of the body. The strongest lamellae are arranged cephalocaudad in the direction of pressure from above downward. These stronger vertical bars of cancellous bone are bound together by weaker horizontal lamellae. The vertical fibers of bone are curved with their concavities directed toward the center of the bone; the horizontal ones are slightly curved parallel with the upper and lower surfaces, and have their convexities toward the center of the bone. The vertical set is more defined than the horizontal set. The cancellous tissue of the body is covered with a thin layer of compact bone.

The number of vertebrae permits a considerable amount of movement in the complete column without calling for more than a very small amount between the individual segments, thus avoiding the weakening that would result if the segments were fewer and longer. The mechanical stability of the column under all normal movements is assured by having the axis of rotation pass through the bodies and not through the arches, so that the bodies are not displaced from one another. To this end the discs join the bodies together and the thicker the disc the greater the amount of movement between the bodies. Thus we find that the discs are thickest in the lumbar and cervical regions, where movement is freest, and shallow in the dorsal series, where naturally the amount of motion is much restricted. In addition to the intervertebral discs we find the bodies attached by the anterior and posterior common ligaments. The whole series of bodies form a flexible column with the discs ensheathed in a white fibrous covering.

It is evident that a forward bending of the column will lead to a separation between the corresponding laminae and spines, and thus we find that the laminae are connected with those above and below by interlaminar ligaments (ligamenta subflava) mostly pure elastic tissue. The separation of the transverse processes in lateral flexion of the column is met by the intertransverse muscles and considerable white fibrous tissue. Lateral flexion is more limited than ventral flexion.

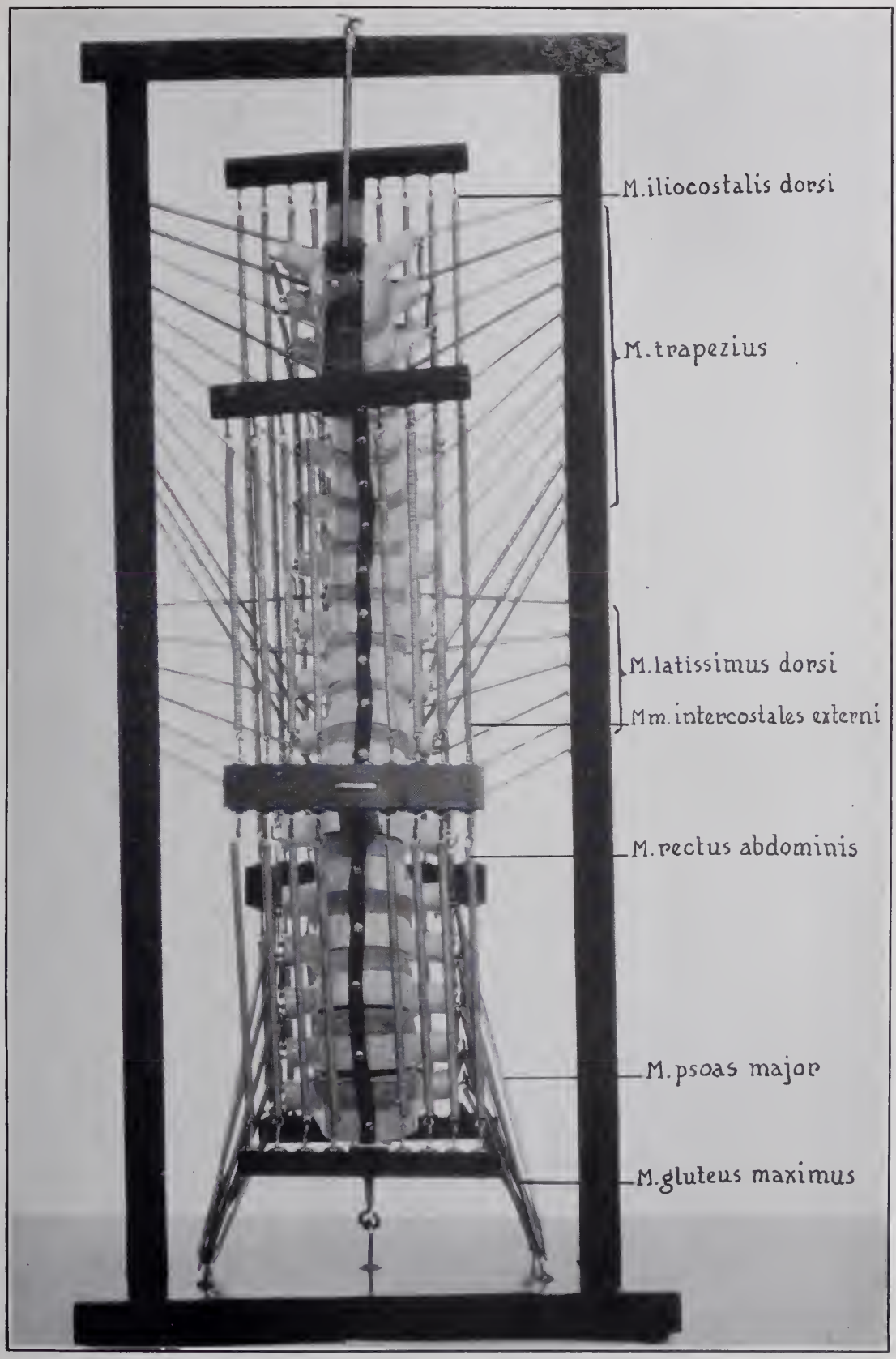
We may sum up the movements between the parts of the different vertebrae as follows: the bodies, being in and around the center of motion or gravity, move least, and the various processes move more, in proportion as they are far away from the body in the plane of any specific movement. The cord, with its meninges, lies deep to the neural arch. This arch moves away from or to its neighbors in flexion or extension and thus the cord obtains the greatest possible amount of freedom from action by having no attachments to the arches. The cord is held to the dorsal aspect of the corporeal column by the adhesion of the pachymeninges to the dorsal common ligament and by the attachment of its nerves to the pedicles and discs through their sheaths of dura mater.

Embryology of the Spine

The detailed examination of roentgenographs of the spine at different ages is necessary in studying the embryology of the spine. One should note changes in size,

Fig. 2 ⟶

Fig. 2.—Ventral aspect of the dynamic muscle-bone balance model of the human spine (about one-fifth natural size). The spine has no direct solid support but is suspended in a backpressure field which is a resultant of the bilaterally balanced spring tensions. The black elastic band extending vertically over the midventral aspect of the bodies of the vertebrae represents the middle longitudinal ligament.


M.iliocostalis dorsi
M.trapezius
M.latissimus dorsi
Mm.intercostales externi
M.rectus abdominis
M.psoas major
M.gluteus maximus

shape, position, relations and density of the segments of the vertebral column, and should keep in mind the sequence of phenomena that takes place in endochondral ossification of the vertebral pillar of support and laminar protection. The general outline of the bones should be compared with a known standard. Irregularities, lipping, exostoses and radiability of the periosteum must be considered. The reliability of a roentgenologist's report of objective observations (not clinical diagnoses) rests upon keen observation and wide clinical experience. A normal or standard must be set as to the normal densities of the bones and surrounding parts of the vertebral column at different anatomic ages. Then, and then only, is he able to report objectively with assurance and certitude, in cases of nutritional disturbances, whether or not there has been an increase or decrease of surface, outline or density of bone in the various vertebrae.

Evaluation of changes in the epiphyseal lines due to infection, trauma or disturbed nutrition depends upon a knowledge of the normal, and evaluation of the degree of variation from the normal depends upon the criterion or standard that has been set by observational study. This variable standard, which changes with progressive development of the anatomic age, definitely in the mind of the roentgenologist, makes the interpretation of a slight degree of irregularity from disease possible. It should be noted whether or not the epiphyses of the various segments have appeared, and, if so, their density, condition and size.

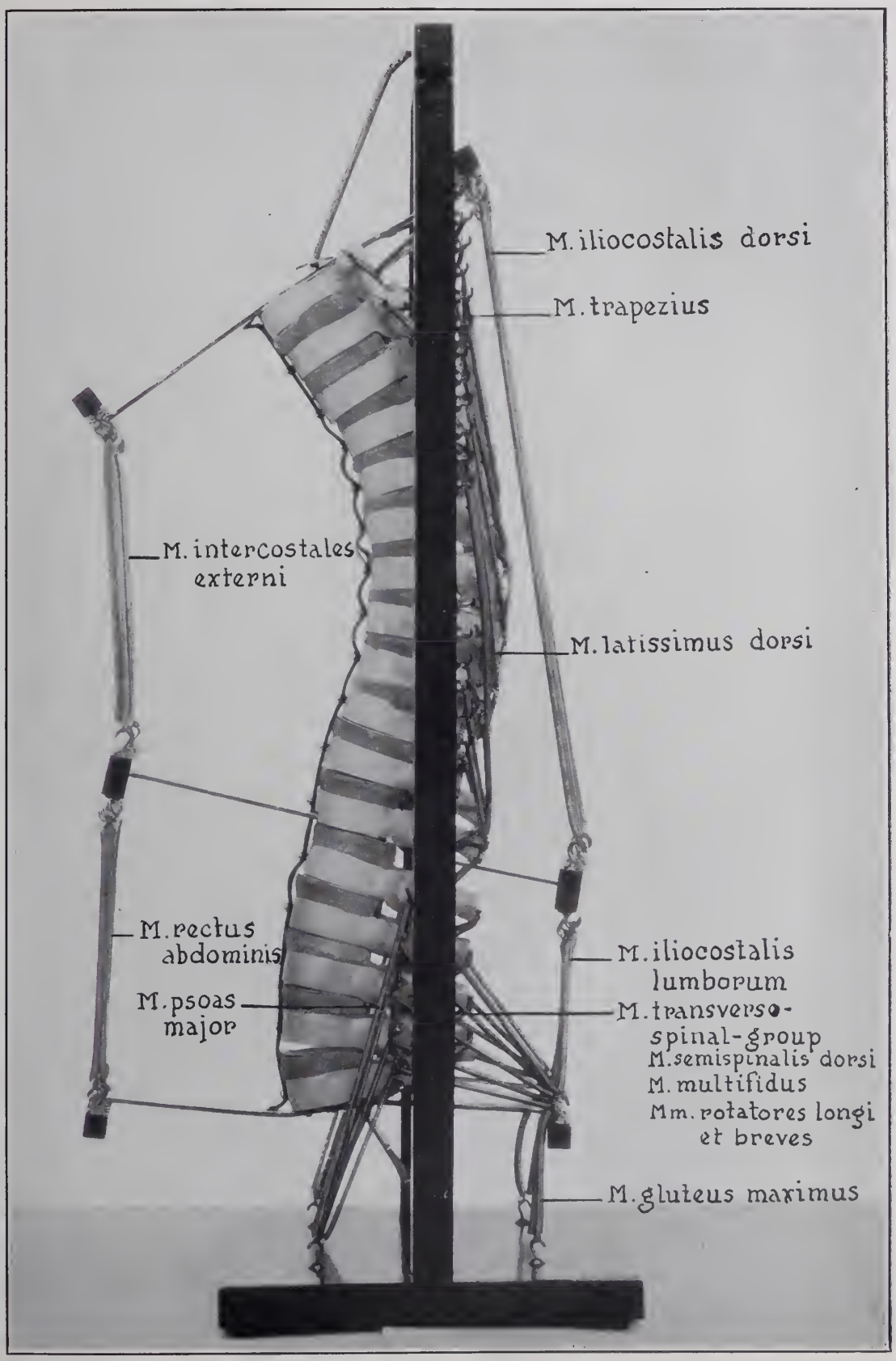
We must admit that we are studying histology and pathology in its most important aspect, that is, under living conditions, and that a knowledge of these conditions is exceedingly valuable not only for diagnosis but for treatment. We must remember that although the knowledge we obtain from the microscope is of very great value, yet at times macroscopic pictures are as useful as microscopic ones. A magnifying glass is of great use in studying reproductions of roentgenograms of the spine. This glass is of great use in the study of the chronologic and anatomic changes of the developing spine.

The vertebrae are ossified by the endochondral method. The cartilaginous structure has a centrum and two separate halves of a neural arch, with the varying processes represented at first only by the scleroblastemal skeleton, into which the chondrifying process takes place. Ossification begins during the seventh week by the formation of three primary centers, one for the centrum of the body and one for each half of the neural arch. The center for the body is either bilobed or double in origin, fusing rapidly into one bilobed center of ossification.

In the radiograph the ossifying process is not detected prior to the ninth week. At this time the centers for the arches of the cervical vertebrae appear, progressively in order, from above downward. While each part passes through its own cycle of changes, these changes as a whole tend to follow the law of *developmental direction* for it is generally found that development, including growth and differentiation in the long axis of the body, appears first in the cephalic aspect of the body and progresses caudad and similarly development in the transverse plane begins in the mid-dorsal region and

Fig. 3 →

Fig. 3.—Lateral aspect of the dynamic muscle-bone balance model of the human spine (about one-fifth natural size). The spine has no direct solid support but is suspended in a backpressure field produced by the bilaterally balanced tensions of steel wire springs. The ventral concavity in the thoracic and the ventral convexity in the lumbar regions are produced by differential tensions of the steel wire springs. The transverse wooden bars represent the upper and lower limits of the thoracic cage and the pelvis, the pubis ventrad and the sacrum, ilium and ischium dorsad. The ventral convexity of the lumbar region of the spine is the result of the two muscular forces, (1) the bowstring effect of two powerful muscles, the sacro-spinales and their synergists, and (2) the ventral traction of the psoas majores. The ventral convexity of the cervical vertebrae is likewise a result of the bowstring muscles of the back of the neck. The lumbar and cervical compensatory curves are developed with the increase of power of the dorsal spinal extensor musculature in maintaining the spine erect. The cervical convexity develops from three to six months after birth when the head is flexed and maintained in the upright extended position when the child begins to sit unaided. The lumbar curve develops from nine to twelve months after birth with the ability of the growing child to sit, stand and walk with the spine vertically placed.


M. iliocostalis dorsi
M. trapezius
M. intercostales externi
M. latissimus dorsi
M. rectus abdominis
M. psoas major
M. iliocostalis lumborum
M. transverso-spinal-group
M. semispinalis dorsi
M. multifidus
Mm. rotatores longi et breves
M. gluteus maximus

progresses lateral and ventrad, while in the extremities it extends proximodistad.

The primary centers of ossification appear, therefore, at different times in different regions; thus, those for the *arches* appear first in the cervical region, and succeed one another from above downwards while the *centrum* ossifies earliest in the mid-dorsal regions and extends thence in both directions cephalad and caudad. The ossification of the arches is associated with the determinant induced changes caused by the progressive development of the musculature from above downwards and the ossification of the bodies of the vertebrae with the first appearance of an adequate optimum location of pressure.

The cervical *arches*, therefore, ossify before the *bodies*, while in the mid and lower dorsal and lumbar region the *bodies* ossify before their corresponding *arches*. The rapidity of the extension of ossification has individual variations but by the end of the third month there are primary centers for all the true or movable vertebrae (cervical, dorsal and lumbar).

At birth the three primary bone centers are distinct, but joined by cartilage. The arches join dorsally during the first year; fusion commences in the lumbar region. A few years later the arches join the bodies; this process commences in the dorsal region.

After puberty secondary centers appear and fuse with the primary bone by the age of twenty-one years. These appear in the cartilage covering the upper and lower surfaces of the body, epiphyseal plates and the tips of the transverse and spinous processes. The epiphyses on the body only ossify at the periphery of the cartilaginous plate, the central part remaining cartilaginous, but in advanced life this also may be ossified.

At the seventh intra-uterine month there is seen a rudimentary atlas and axis and then the vertebral column through its whole length. Especially marked is the extreme radiability of the intervertebral discs in comparison with the lessened radiability of the bodies of the vertebrae, which, however, also show a cartilaginous condition of the transverse processes throughout the whole length of the spine. Starting from above it should be noted in comparison with the radiability in the cardiac region, where the density of the heart is added to that of the spine.

At the sixth month of extra-uterine life the radiability has gradually decreased due to increased ossification of the vertebrae, whereas at two years the transverse processes of the cervical vertebrae are considerably condensed and cast a shadow. At the third year there is no especial change in the density of the cervical vertebrae. The lumbar vertebrae are, however, unusually distinct and show decidedly lessened radiability in their bodies.

During the sixth year the bodies and the transverse processes have become much more ossified and have greater density and lessened radiability.

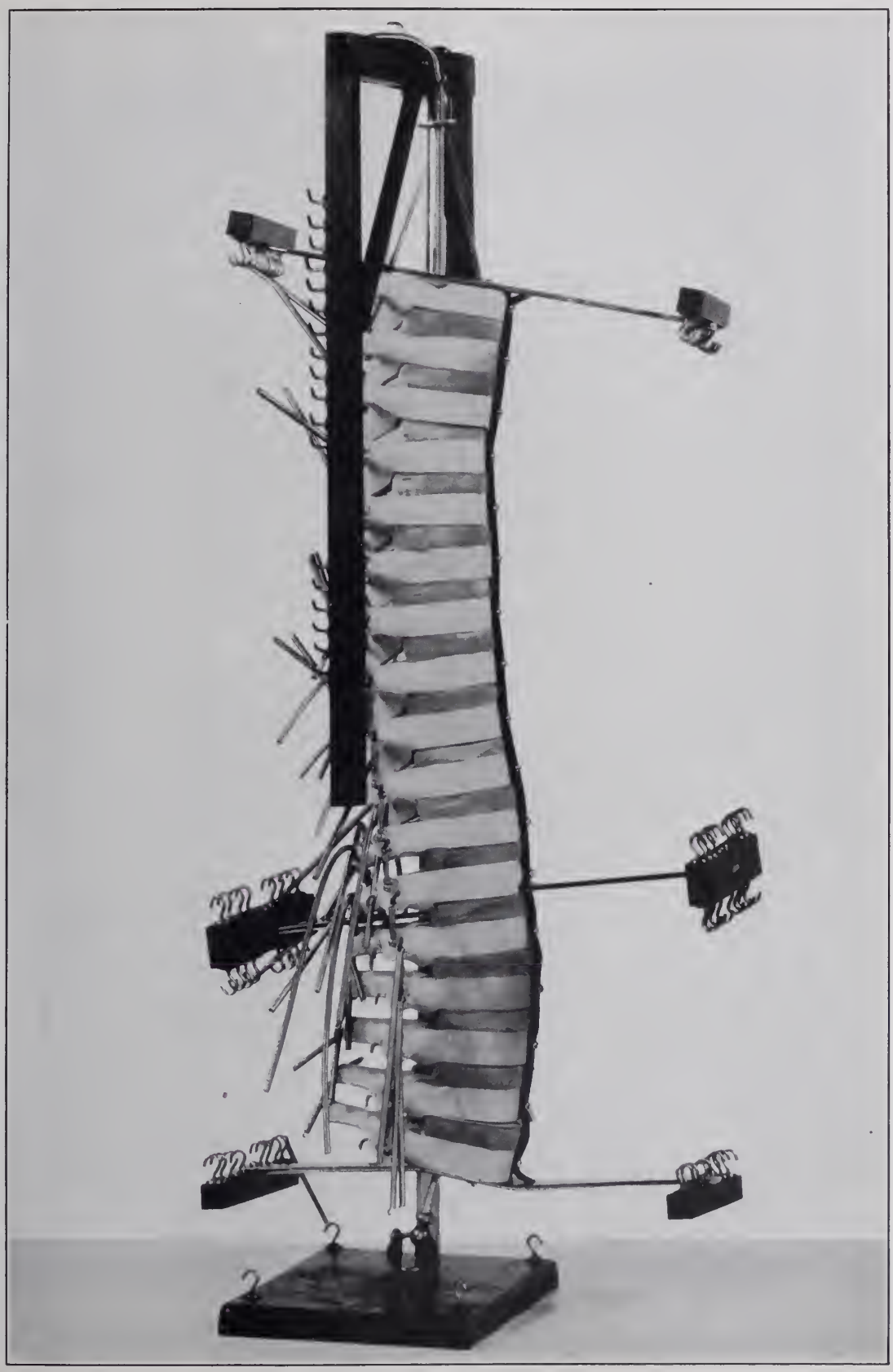
Pathogenesis of Rotary Lateral Curvature of the Spine

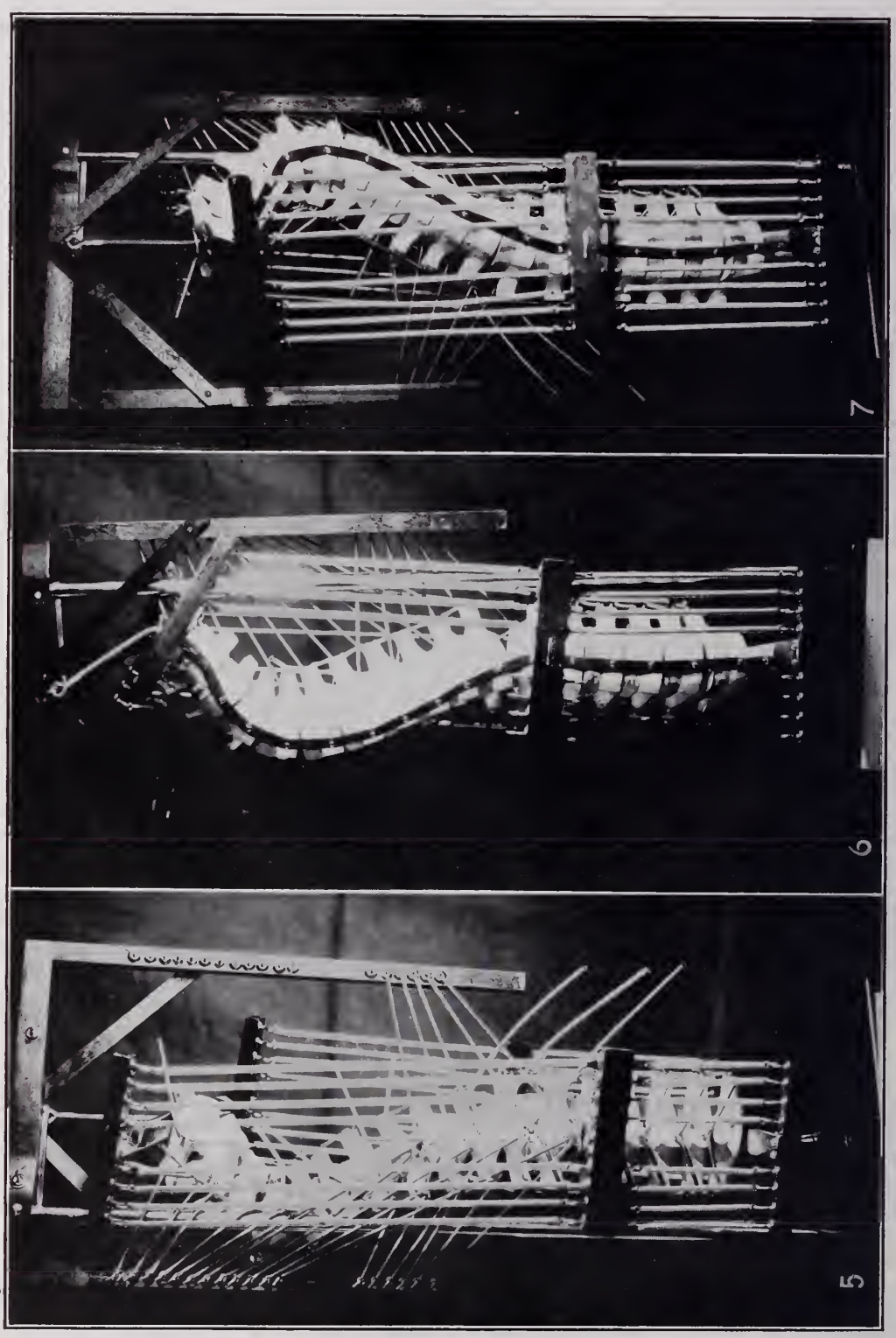
The dynamic equilibrium of the muscle and bone of the back, leading to permanent structural changes in the bodies of the vertebrae, intervertebral discs, ribs, shoulder and pelvic girdles and lower extremities, may be upset by different pathologic conditions in the following systems of the body: (1) digestive; (2) blood and lymph vascular; (3) respiratory; (4) excretory; (5) nervous; (6) osseous; (7) joint; and (8) muscular systems. Congenital changes that are the result of arrested growth or overgrowth of certain bones or muscles cause alterations of normal balance of the motor system of the back.

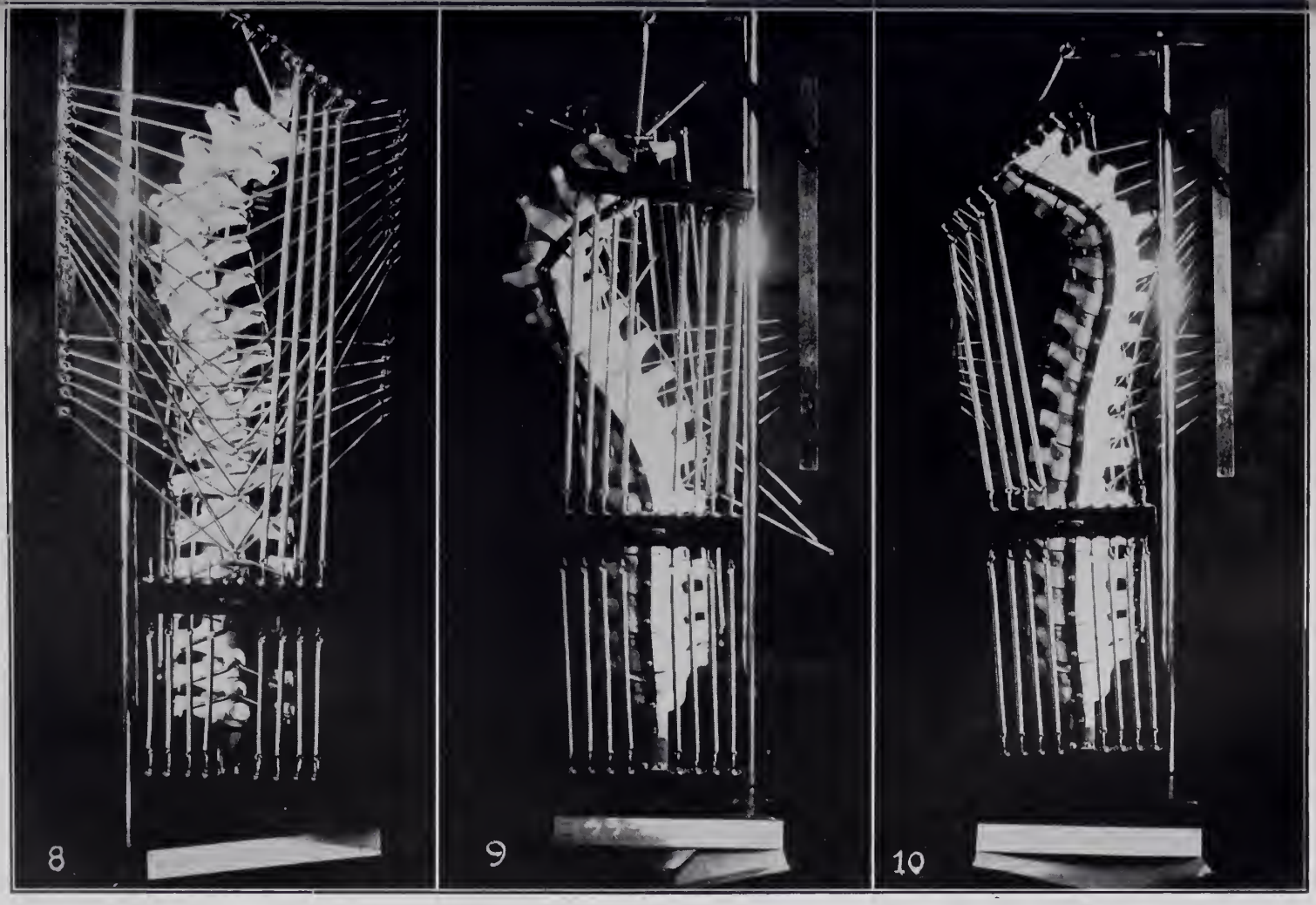
The mechanism of production of the different degrees and types of rotary lateral curvature may be best studied by means of the dynamic muscle-bone balance model of the human spine. This model of the dorsolumbar vertebrae of the human spine in wood and related musculature in steel wire springs was constructed in order to visualize the interdependence and interactivity of the bilateral and unilateral muscular actions in relation to the spinal column indicator. The spinal column is demonstrated to be a

Fig. 4 →

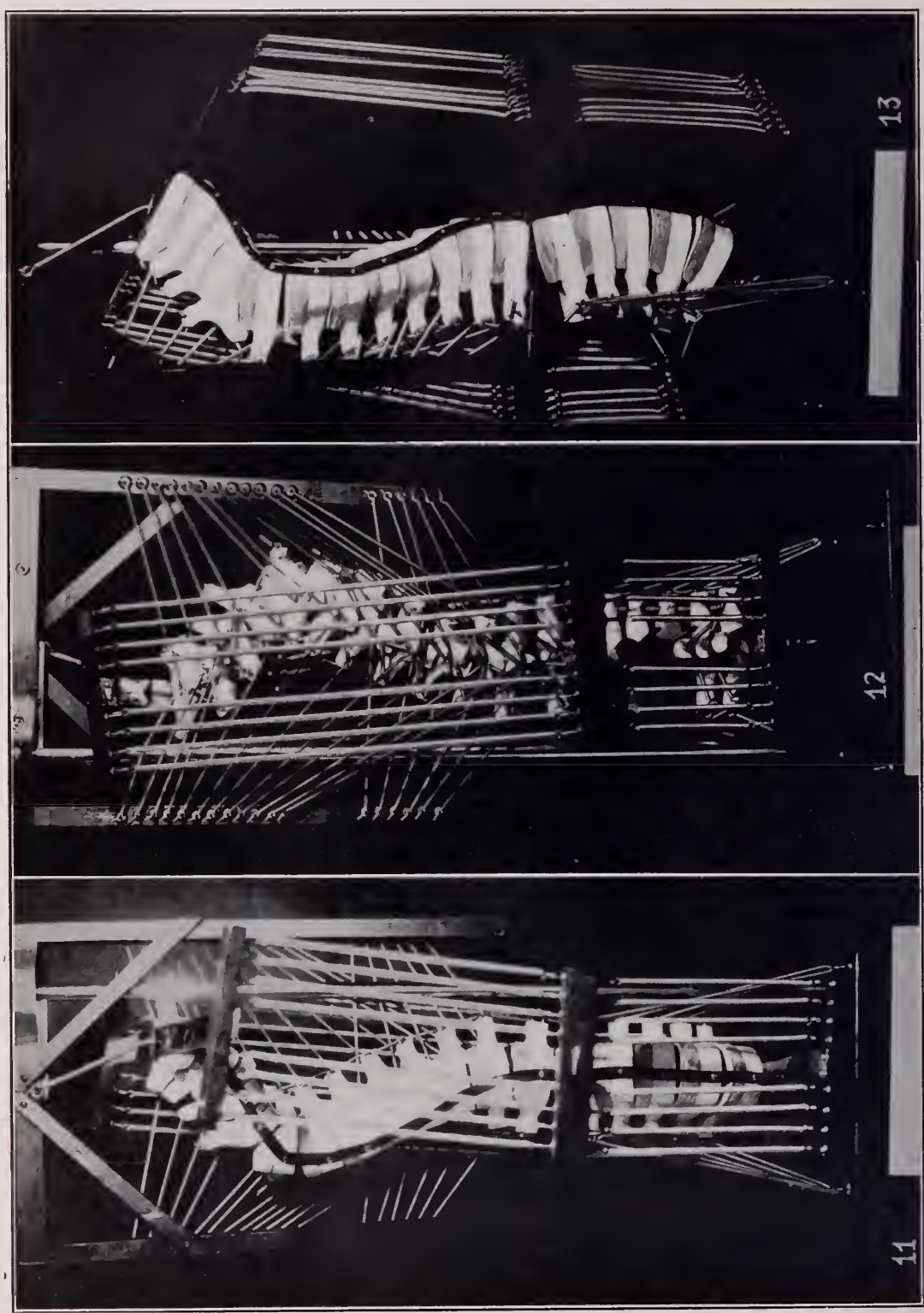
Fig. 4.—Ventrolateral aspect of the dynamic muscle-bone balance model of the human spine (about one-fifth natural size). The spine is stripped of all tensions of the steel springs and the mechanical resultant of the backpressure of spring pull.







Figs. 5 to 10.—Dorsal and ventral aspects of the dynamic muscle-bone balance model of the human spine (one-twelfth natural size). The left lateral scoliosis is produced by the release of the springs on the right side which represent the trapezius muscle (fig. 5). The right lateral scoliosis in the dorsal region is produced by the release of the springs on the right side which represent the right external intercostal muscles (fig. 6). The left lateral scoliosis in the dorsal region is produced by the release of the springs which represent right trapezius muscle (fig. 7). The left lateral scoliosis in the dorsal region is produced by the release of the springs on the left side which represent the left ilio-costalis dorsi muscle (fig. 8). The right lateral scoliosis in the dorsal region is produced by the release of the springs on the left side which represent the left trapezius muscle (fig. 9). The left lateral scoliosis in the dorsal region is produced by the release of the springs on the left side which represent the left external intercostal muscles (fig. 10).



Figs. 11 to 13.—Ventral, dorsal and lateral aspects of the dynamic muscle-bone balance model of the human spine (about one-twelfth natural size). This right lateral scoliosis in the dorsal region has a superimposed convex-sided rotation of the bodies of the vertebrae. This deformity is produced by the release of the springs on the right side which represent the right intertransversarii and the right transversospinal muscles of the dorsal region. When the balance of the deep torsion muscles of the spine is upset there is likewise a tendency of imbalanced action of the superficial spinal muscles.

dynamic indicator of myogenic equilibrium, the result of neurovestibular control on the bilateral muscles pulling against the resistance of gravity.

This results in body symmetry or asymmetry of balanced or imbalanced muscular activities, respectively. The spine and its neuromuscular relations constitute a functional unit and are roughly analogous to the indicator and its relation in the balance scales. The spinal indicator may, however, be laterally deviated to the stronger or to the weaker muscle side. This depends on whether or not the parallel bowstring or the transverse-traction muscles, acting directly or indirectly on the spine, are unilaterally stronger than a weakened antagonist on the opposite side of the body.

In figures 1, 2, 3 and 4 the axial spine is shown in different aspects in relation to the musculature. I have reclassified the musculature that influences spinal position on a physiologic basis, with examples in each class, as follows:

1. The superficial parallel bowstring muscles: rectus abdominis, intercostals, sacrospinalis muscles.
2. The deep parallel bowstring muscles: intertransversarii.
3. The superficial transverse-traction-torsion muscles: trapezius, latissimus dorsi, serratus anterior and pectoralis major muscles.
4. The deep torsion muscles: semispinalis, multifidus, long and short rotator muscles.

In the primary curvature the convexity of the spine was toward the strong muscle side when the superficial transverse-traction-torsion muscle was unilaterally weakened (figs. 5, 7 and 9). If the right trapezius muscle was weakened or paralyzed, the overaction of the unopposed left trapezius muscle drew the convexity of the spine toward the left side (figs. 5 and 7). The unopposed action of the right trapezius muscle pulled the convexity of the spine toward the right side (fig. 9).

When the superficial parallel bowstring muscles of the body were weakened or paralyzed, the convexity of the spine was directed toward the weakened side (figs. 6, 8 and 10). If the right external intercostal muscles or the rectus abdominis muscle were weakened or paralyzed, those on the left side acted as a bowstring and forced the convexity of the spine to the opposite or right side (figs. 6 and 10). The convexity of the spine was directed to the left side when the left iliocostalis dorsi muscle was paralyzed. This was due to the unopposed action of the right parallel bowstring muscles (fig. 8).

When the right intertransversarii and the right transversospinal muscles were weakened or paralyzed the unopposed action of the muscle group of the left side caused a right convex scoliosis with a rotation of the bodies of the vertebrae to the side of the convexity (figs. 11, 12 and 13). In this case, convex-sided torsion of the bodies of the vertebrae was a resultant of the imbalanced action of the deep torsion muscles of the spine.

Definite torsion of the vertebral column and relatively little lateral displacement were produced when the transversospinal muscles were unilaterally weakened or paralyzed (figs. 14, 15, 16 and 17). By the elimination of the action of the superficial muscles of the body, the pure effect of the deep torsion muscles was demonstrated. By releasing the action of the right transversospinal muscles, the unopposed action of the left ones rotated the bodies of the spine to the opposite or toward the right side (figs. 14 and 15). The reverse effect was produced when the left transversospinal muscles were released from action. The overacting right transversospinal muscles rotated the bodies to the opposite or to the left side (figs. 15 and 16). The bodies of the vertebrae may be made to rotate toward the side of the convexity or toward the concavity of the curvature, depending on which side the intertransversarii were paralyzed. The lateral deviation of the spine and concave and convex-sided torsion of the bodies of the vertebrae were resultants of the imbalanced actions of different combinations of the muscle groups of the body.

There are numerous possible combinations of muscular imbalance. With only thirteen pairs of spinal muscles there are more than sixty-seven million possible combinations of muscular imbalances resolved by the mathematical formula $(2^n - 1)$. There are 144

muscles directly attached to the movable spine. The mind is unable to conceive the result of multiplying out to the one hundred and forty-fourth power: $2 \times 1 = 2$ (second power) $\times 2 = 4$ (third power) $\times 2 = 8$, and so on to the one hundred and forty-fourth power.

Different groups of imbalanced muscles may produce the same type of spinal curvature. The clinician meets a definite practical difficulty, therefore, when he tries to assign to any single muscle group or combination of muscle groups the cause of a specific curvature of the spine.

Prevention of Defects

Any agent that upsets the normal dynamic equilibrium of the motor system of the back will be evident in the spinal indicator of muscle balance and imbalance. The motor system of the back is maintained in normal balance by the functional integrity of the blood, nerves, muscles, tendons, bones and joints. These six anatomic phases form a physiologic system of motion. During the first decade of life, even under apparently normal conditions there is found by Baker* an undernourishment in 25.2 per cent of school children before 10 years of age. This results in a dystrophy of muscle and bone growth. The dominant muscular atrophy is focal and asymmetrical. This dissociation of muscular and skeletal growth is more dominant in girls than in boys.

The focal muscular atrophy and paralysis of under-nutrition will upset the muscle-bone balance of the normal spine and may well be the insidious cause of idiopathic scoliosis. The problem of scoliosis is then a problem of prevention of all conditions that upset the normal balance of muscle and bone during growth. This has been proved by Müller* and myself* on experimental animals in the production and prevention of myogenic scoliosis. Steindler* has a similar point of view in preventing structural scoliosis by the elimination of those generalized debilitating conditions that he designates prescoliosis.

Conclusions

1. In low back pain it is important for the general practitioner to examine carefully the living anatomy of the spine and its relations. The subject of scoliosis is considered because it reveals the importance of an exact anatomic knowledge as a basis for examinations and diagnosis of any derangement of the back.

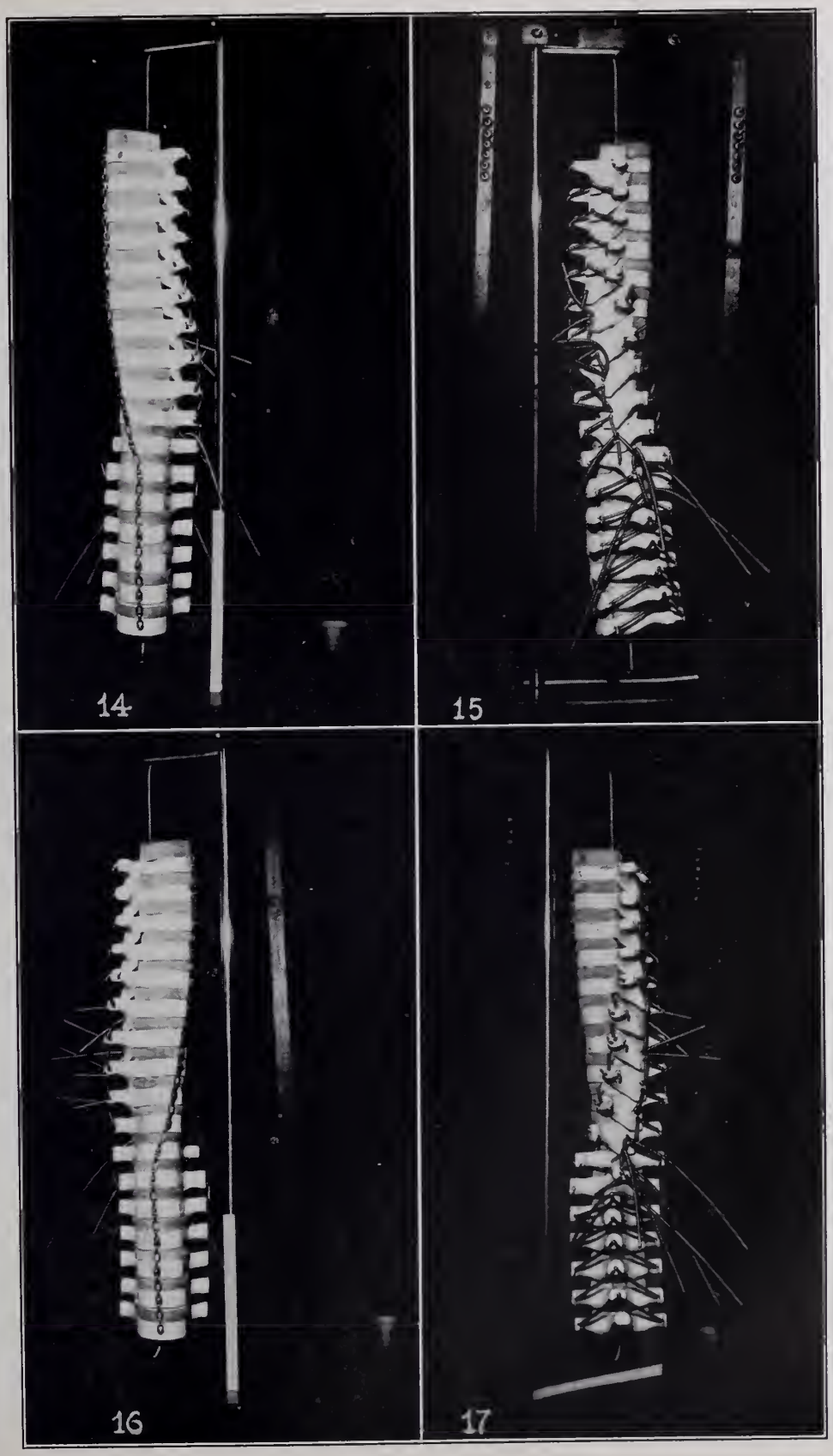
2. Scoliosis is a spinal sign of the imbalance of muscle and bone growth of the motor system of the back and is not a specific disease entity. The dynamic interrelationship of muscle, tendon, ligament, bone, nerve and blood supply is important to emphasize. The kind and degree of scoliosis are dependent on the extent of the imbalance, caused by the weakening and possible paralysis of multiple combinations and permutations of the muscle groups of the body as a whole. Accurate anatomic and physiologic knowledge of the motor system of the back as a functional whole is necessary for an understanding of pathologic changes in the spine.

3. In chronic infantile inanition and malnutrition there is a decrease in muscle weight and a persistence in skeletal growth in length. The muscles do not degenerate uniformly. This asymmetrical focal muscular atrophy and localized muscular weakness or paralysis of the undernourished child are more pronounced in girls than in boys. The result is unequal pull on the spine and the striking of an abnormal muscle-bone balance. This inequality of muscular atrophy and paralysis upsets the normal dynamic equilibrium of the muscle and bone growth of the spine. Chronic underfeeding or malnutrition of the child during the first decade of life is,

Figs. 14 to 17 →

Figs. 14 to 17.—Ventral and dorsal aspects of the dynamic muscle-bone balance model of the human spine (one-twelfth natural size). The springs that represent the superficial muscles acting on the spine are stripped from the model. The intertransversarii and the transversospinal muscles are retained. Marked torsion is produced with relatively little lateral deviation of the spine when there is imbalanced action of these deep torsion muscles. The bodies of the vertebrae rotate to the right when the right transversospinal muscles (springs) are released from action (figs. 14 and 15). The bodies of the vertebrae rotate to the left when the springs that represent the left transversospinal muscles are released from action in the dorsal region (figs. 16 and 17). When the intertransversarii act on one side there is a slight bowstring effect with the convexity of the spine directed to the opposite side.

* For reference, see page 493.


14
15
16
17

therefore, suggested as the insidious cause of idiopathic structural scoliosis.

4. The convexity of the laterally deviated spine may be toward either the stronger or the weaker muscle side.

5. The convexity is toward the weak muscle side when the parallel bowstring muscles are dominantly weakened on the side of the convexity of the primary curve of the scoliotic spine.

6. The convexity is toward the strong muscle side when the superficial transverse-traction-torsion muscles are dominantly weakened on the side of the concavity of the scoliosis.

7. There is a definite lateral deviation of the spine with relatively slight rotation of the bodies of the vertebrae when the large superficial muscles of the body are dominantly imbalanced.

8. There is definite rotation or torsion of the spine with relatively slight lateral displacement when the deep intrinsic muscles of the spine are dominantly imbalanced.

9. In clinical practice there are all combinations of imbalance involving eventually both the superficial and the deep intrinsic muscles of the spine where scoliosis is found.

10. Concave and convex sided rotations of the bodies of the vertebrae are resultants of the imbalance of different groups of muscles of the body as a whole.

11. These facts have been proved experimentally on animals and are demonstrated on the muscle-bone-balance model of the human spine, which visualizes the normal and abnormal dynamic equilibrium of the bilateral body muscles, recorded in the spinal indicator.

12. The problem of scoliosis is, therefore, fundamentally one of prevention of all conditions which upset the normal dynamic balance of muscle and bone during the period of growth, such as chronic inanition and malnutrition, and the various types of chronic diseases, which lead to undernourishment of the growing child.

13. During growth and maturity the components of the motor system of the back differentiate and function as a physiologic, interactive whole and not as a mere mosaic of passive, autonomic and independent anatomic parts. This dynamic point of view is opposed to the static one, which holds that the bone of the spine or any other bone in the body is originated and maintained independent of environment.

2. Medical Aspect

By GEORGE H. COLEMAN, M. D.
Chicago

LOW back pain, with or without sciatic involvement, is a relatively common complaint. Patients presenting this symptom complex, either protracted or recurrent, account for a fair percentage of the office and clinic practice of the general practitioner and internist. During the years 1935, 1936 and 1937 in the Mayo Clinic, Love[1] reports that over 13,000 patients were referred to the orthopedic department for consultation and treatment because of backache.

Before asking for advice, patients with backache usually try the various home remedies, the many drugs and applications so widely touted over the radio and in health columns, and massage and osteopathic manipulations, with indifferent results. Relief is demanded because low back pain produces a great sense of fatigue as well as of incapacitation. Willis[2] states "The human back is particularly subject to aches of muscle, joint and ligamentous origin because of its complicated structure, its adoption of the upright posture, and because of frequent defects of development in the lumbosacral area, some of which are serious mechanical faults."

Inasmuch as low back pain is only a symptom and may result from such a variety of causes, each patient presents a problem in diagnosis, frequently one requiring a careful and diligent search before the true etiological factors can be ascertained. If there has been no satisfactory response to conserva-

tive measures such as heat, rest in bed and physical therapy, the search for the cause must be persisted in by the physician. He should determine if the cause is purely *medical,* in the restricted sense of the word, and, if not, refer the patient directly or in consultation to the orthopedic surgeon, the neurologist, the urologist or gynecologist.

Needless to say, examination of the patient disrobed, with special attention to the gait, posture and the range of motion of the spinal column will often lead to a more rapid as well as a more accurate diagnosis. Furthermore, a careful history extending back many years will frequently prove to be of great value.

Routine examination should include serological testing of the blood for syphilis, gonorrhea and undulant fever; determination of the blood sedimentation rate; routine blood count; and urinalysis. Foci of infection should be ferreted out whenever possible. In addition to a search for the more common foci in the teeth, tonsils, tonsil stubs, nasal accessory sinuses and upper respiratory tract, examination should be made of the prostate and seminal vesicles, the uterus and adnexa, and the rectum. Stool cultures for Streptococcus hemolyticus or the bacillary dysentery and typhoid group, especially where there has been a history of bowel disturbance such as colitis or diverticulitis, offer a solution in a limited number of cases. Chronic gallbladder disease may be important if present. Roentgenograms of the spine and pelvis should include an oblique view in addition to the usual anteroposterior and lateral views.

The backache complicating the acute infectious diseases, including grippe and the eruptive fevers, is without the scope of the present discussion. We are concerned with a consideration of chronic backache, chronic rheumatism and lumbago.

Frequent Etiologic Factors and Symptoms

Pain in the back may be referred from distal organs, such as the gallbladder, stomach and intestines, pancreas, diaphragmatic hernia (rarely), and from lesions of the aorta. These are more apt to produce discomfort in the thoracic and upper lumbar portions of the spine, but may occasionally be referred to the lower lumbar segments. Several such observations have been reported by Jones,[3] Mixter,[4] and others.

Pain may result from diseased or malposed organs lying contiguously to the back, notably the rectum or sigmoid, prostate and seminal vesicles, the urinary bladder and female pelvic organs. Even in severe constipation, rectal impaction and Hirschsprung's disease, pain may be experienced over the areas of distribution of the third, fourth and fifth sacral nerves.

Such discomfort may occur in the presence of general vascular disease, Bright's disease and metabolic disturbances as in diabetes mellitus and gout. It may be a prominent symptom in chronic intoxications, chiefly those due to alcohol, lead or arsenic.

Quite frequently backache is due to involvement of the soft structures surrounding and supporting the spine, such as injury or inflammation of the muscles, aponeuroses and nerves with muscle spasm.

It may be the result of excessive physical fatigue or tears of the muscles and ligaments; it may accompany myositis, fibrositis or myofascitis and polyneuritis. One very common example of this type is the pain often complained of in the early summer when too vigorous exercise is indulged in after months of inactivity during the winter and spring.

Kimberley[5] states: "Often lifting is done near the extremes of motion permitted by the spinal joints, so that its leverage is great and the resultant stresses magnified. Faults of posture increase the stresses present in proportion as they shift the axis of weight bearing from a center passing through the lumbosacral junction."

In recent years, special inquiry has been made into what is apparently an important member of the rheumatoid group, classified originally by the English as "white fibrositis"—now better known as myofascitis, a lesion consisting of an inflammatory reaction of the fibrous tissues of the body with involvement of the interstitial tissue of muscle but rarely of the muscle parenchyma. Traeger[6] advances a classification in which fibrositis may be primary and independent of any detectable change elsewhere or secondary to rheumatic fever, rheumatoid arth-

ritis, gonorrheal rheumatism and certain traumas. He also notes a senile type in which the gradual fibrotic changes of senescence become evident. The pathology is not well understood due to lack of biopsy and autopsy material. Albee[7] states that Schade has noted some round-cell infiltration and a peculiar physiochemical change in the interstitial substance of the muscle for which change he has coined the term "myogelosis." In Albee's experience "the most frequent localization of the pain (54 per cent) is the lower back where there are so many fascial insertions into the bone." He found it to occur more often on the left side and, not infrequently, to involve the gluteal and hamstring muscles.

Involvement of the subcutaneous tissue, including areolar and adipose tissue, may be noted. When cervical fibrositis exists, it may lead to symptoms of indurative headache. When the chest wall is involved it may be called pleurodynia. Or an abdominal fibrositis may occur in which there is little if any muscle spasm or rigidity but exquisite tenderness to finger tip pressure. Muscle fascial planes as well as interstitial tissue may be affected. Periarticular fibrositis may be suspected when tenderness and pain occur only on abnormal stretching of the capsule. Traeger[6] describes a bursal form of fibrositis in which there is increased fluid in the bursal sac without calcification, pain being present only on extremes of motion with little, if any, limitation of motion. Interstitial tendinitis and neuritis are also described by Traeger. In the fibrositic form of sciatica, the pain is referred to the hamstring muscles and not to the nerve trunk. In perineural fibrositis, as distinguished from true sciatic neuritis, the pain follows the nerve distribution without anesthesia or paresthesia over the area of nerve distribution. In sciatic fibrositis the pain is less severe and there is more muscle stiffness and superficial tenderness.

Myofascitis is rather sharply differentiated from rheumatoid arthritis in that it is usually confined to a local area, is painful only on forced extension or movement, is relieved by exercise and moderate movement, does not result in muscle atrophy, is subject to frequent remissions, never produces synovial exudations or systemic manifestations and further shows no changes in the x-ray film or in the blood sedimentation rate. The more acute the onset, the more rapid the cure.

Chronic backache may be due to disease or deformity of the vertebrae, vertebral articulations or sacroiliac joints. The lumbosacral junction is the most vulnerable portion of the spine and is subject to the greatest strain. Here one must look for atypical vertebrae, sacralization of the fifth lumbar vertebra, spina bifida, spondylolisthesis, changes due to rickets, tuberculous involvement of the spine, infectious osteoarthritis and degenerative osteoarthrosis of the spine. It is important to detect fractures or dislocations if present.

Role of Chronic Rheumatism

Chronic rheumatism is a general term and comprises two distinct diseases, each differing from the other, in etiology, pathology, clinical signs and symptoms. In 1909, after careful pathological study, Nichols and Richardson[8] divided rheumatic joint lesions into two definite pathologic groups: (1) those which arise from primary proliferative changes in the joints, chiefly in the synovial membrane and in the perichondrium, variously designated as rheumatoid or infectious or atrophic arthritis and arthritis deformans; (2) those which arise primarily as a degeneration of the joint cartilage, variously called osteoarthritis, hypertrophic and degenerative arthritis. More recently this latter type has become known as osteoarthrosis. Mixed types are frequently found. Arthritis of the spine or spondylitis may be of either type or mixed. Rheumatoid arthritis of the spine or spondylitis ankylopoietica, the term used by Fraenkel in 1904 but previously described by Strümpell and Marie, may develop as a complication of a number of infective diseases—such as gonorrhea, bacillary dysentery, typhoid fever, influenza, and brucellosis—including rheumatoid arthritis of the extremities. As it involves the synovium, and as the intervertebral discs do not have a synovium, the disease attacks the small articulations and those of the transverse processes and the ribs. There is probably an early attempt at ankylosis with re-

sultant early strophic changes in the involved vertebrae and later a firmer ankylosis ensues. After considerable time, certain sequelae develop, probably in the following order: (1) ossification of the intervertebral ligaments, especially the anterior longitudinal ligament; (2) invasion of the spongiosa of a vertebra of the adjacent central portion of the disc and penetration through it to the spongiosa in the neighboring vertebra; and (3) possible ossification of the periphery of the disc. This may ultimately lead to the formation of the so-called "bamboo spine" or "poker spine."

Fisher[9] gave the following definition of osteoarthritis: "Osteoarthritis (hypertrophic arthritis) does not constitute a disease *sui generis,* but rather the series of physiological and pathological changes that occur in a joint when it is subjected to prolonged or oft-repeated injury, either mechanical or toxic, but of a moderate degree of intensity." Acute severe injury may give rise to similar changes. Schmorl and Junghanns,[10] Jones,[3] Fisher,[9] Nichols and Richardson,[8] and many others have made exhaustive studies of this condition. Schmorl examined over 10,000 spines removed at autopsy.

It is in this type of spondylitis that osteophytes develop. They arise, not on the rim of the vertebra, but slightly above and corresponding to the points of attachment of the anterior longitudinal ligament.

The intervertebral discs are made of the annulus fibrosus and the nucleus pulposus. They function as shock absorbers and also assist in the rotation of the spine. They are formed by interlacing fibrous tissue with a mucoid fluid in the interspaces. Both begin to show degenerative changes as early as the third decade. The earliest changes are found in the nucleus pulposus and consist in loss of fluidity, dessication of the fibers, and finally disintegration. A solid mass is formed which may later become calcified. Somewhat later the annulus fibrosus degenerates. The disc becomes thinned and loses its resiliency with increased mobility of the joint and destruction of the disc. Increased traction on the intervertebral ligaments, particularly the anterior longitudinal ligament, with resultant periosteal trauma, rather than direct impingement of the vertebra, encourages the formation of spurs and osteophytes. According to Miller,[11] Anton Fischer concludes that "the formation of osteophytes on a vertebra is a physiologic response directed toward reconstruction of a spine which has become functionally inefficient." It is well known that high grades of osteoarthrosis of the spine may exist without causing any symptoms. The blood sedimentation rate is not increased in osteoarthrosis but may be markedly increased in rheumatoid arthritis.

Other Common Causes

Low back pain may be due to postural deformities, as in congenital dislocation of the hips, "knock knees," "flat feet," and hip-joint disease; contraction of the tensor fascia lata, as described by Ober; shortened hamstring or achilles tendons; contractures due to burns; and muscular atrophy such as occurs in anterior poliomyelitis and conditions of muscular fatigue from prolonged misuse with marked imbalance and faulty alignment of the pelvis and lumbar spine.

Again pain may result from protrusion or rupture of intervertebral discs, notably the one between the fourth and fifth lumbar vertebra. This is an orthopedic condition which can be diagnosed positively only by means of roentgenograms taken after the injection into the spinal canal of a contrast medium such as lipiodol or air. However, a presumptive diagnosis may be made when there is a history of injury, intractable pain, scoliosis with loss of lumbar lordosis, spasm of the erector spinae mass, diminished or absent achilles tendon reflexes, a positive Lasegue test, narrowing of the fourth or fifth intervertebral space and increased protein content of the spinal fluid.

Pain occurs in certain neurological conditions, such as in intraspinal neoplasms, particularly of the cauda equina and in metastatic lesions of the spine. In these conditions there is more apt to be involvement of the anterior divisions of the spinal nerves, bladder and rectum disturbances, radiation of pain to the genitalia and disassociated paresthesias with motor weakness. There is usually an abnormal reaction in the spinal fluid and cerebrospinal fluid block may be demonstrated.

Treatment

In treatment our chief objective must be to make the proper diagnosis as early as possible in the course of the disease, remove infection, prevent atrophy, contractures or ankylosis and finally to maintain general nutrition and to prevent reinfection.

General measures include rest at first, followed by passive exercise, and later active movement; drugs for the relief of pain and the production of restful sleep; a well balanced, nutritious diet fortified with vitamins if necessary; nonspecific protein fever therapy and the removal of infectious foci. Local measures should include heat by such means as infra-red radiation, diathermy, the inductotherm, hydrotherapy or heliotherapy. These measures should, in each instance, be followed by massage and passive movements, performed gently at first and then with progressing vigor, culminating in active exercise and movement of the affected parts. The orthopedist can give valuable aid, especially when corrective and supportive measures are indicated.

At present many attempts are being made to "short cut" the treatment by the injection into affected areas of novocain, procaine, hydrochloride, "aciform" and other substances. They usually afford but temporary relief and too often are given to relieve pain per se without determining the cause of the disorder.

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3. Urological Aspect

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THERE is no segment of the human body which has to tolerate indispositions of other portions of the body in such astounding proportions as the back. Beside being subject to the many miseries originating within its own structures, it must withstand the insults of a varying number of abnormal conditions originating in near or distant structures. These signals of distress are often so obscure that much thought and differentiation are required to ascertain the true source of the trouble. This difficulty in diagnosis is made more complex when combinations of local and distant disease are present. Consider, for instance, a joint or other tissue involvement of the back by infection, the products of infection or the resultant fibrositis; complete diagnosis obviously includes finding the primary source of the infection or toxemia and proper treatment includes its eradication together with the indicated treatment of the back. Too often, the site of the symptom receives the entire therapeutic consideration. Modern medicine demands that doctors of every branch of medicine have a good working knowledge of back pain, because of the multiplicity of underlying causes.

It is my purpose in this paper to discuss briefly the role that genitourinary organs play, directly or indirectly, in the cause of painful backs.

Since the genitourinary organs are so intimately connected anatomically and yet derive their innervation so diversely, the disease processes, as well as the symptoms de-

rived therefrom are peculiarly prone to be complex.

Urinary Disease

The kidney in its normal position is probably not pertinent to this discussion of low back pain, but the susceptibility of this structure to abnormally low positions, either acquired or congenital, necessitates its inclusion for completeness. Normally the kidney lies extraperitoneally and opposite the eleventh dorsal to the third lumbar vertebra. It derives its innervation from the renal plexus of the sympathetic system along the renal artery. Beside this principal autonomic innervation it receives fibers from the eleventh and twelfth spinal nerves. In a similar way the ureter is supplied by the autonomic nervous system, but the lower and middle thirds receive innervation from correspondingly lower cord segments.

The kidney and ureter, like other visceral organs, may be cut, torn or otherwise injured without causing any sensation. It has been shown that kidney and ureteral pain can be elicited chiefly in response to vital processes, such as spasmodic contraction of their smooth muscle. Kidney pain, therefore, may be caused by any disease process which produces stretching of the renal capsule, incidental to rapid renal enlargement, or stretching of the renal pelvis incidental to its mechanical blockage; or it may be caused by the presence of a foreign body in the pelvis causing spasmodic contractions of pelvic muscles attempting to expel it.

Ureteral pain is due almost entirely to spasmodic muscular contractions caused by the presence of a foreign substance, or by regional ureteritis, ureteral kinks, strictures, or extra-ureteral pressure sufficient to produce partial obstruction. Pressure on surrounding tissues from abnormally placed or abnormally large kidneys produces local pain as does their adherence to and traction on the adjacent parietal peritoneum.

It is a common observation to note pain in an area other than that which is the site of its origin. This is especially true in kidney and ureteral pain. Head has shown that these so-called referred pains are always localized in the same cord segments, through which the viscus in question is supplied. While normally placed kidneys cause local or referred pains to the back in the lower thoracic and upper dorsal segments, abnormally low kidneys and similar disease conditions, by their local presence only, may produce a low back pain.

Low lying kidneys.—It is well understood that low lying kidneys, either congenital or acquired, are more susceptible to pain producing diseases than kidneys in their normal location. This tendency is made especially apparent in low lying kidneys when it is observed that they have a high incidence of deficient emptying power, characterized clinically by varying degrees of hydronephrosis. While all such types of renal pelvic dilatation do not cause pain, many do produce a local, often obscure and intermittent distress. To be sure this pain is more often referred in front, but it may be referred to the back only, or there may be a combination of the two.

Examination of the voided urine may show it to be normal, but lack of suggestive findings here should not rule out the upper urinary tract as a possible cause of the back pain. Unless there be found a very plausible cause from a local or other distant source, visualization of the upper portion of the urinary tract is indicated. This is especially important if the pain is definitely intermittent. Intravenous urograms usually suffice to clear up the problem as far as the urinary tract is concerned.

These incompletely draining kidney pelves encourage renal infections, after which there is an increased incidence of local pain. Of course, the added findings of pus and bacteria in the urine and other symptoms of renal infection make the picture less obscure and should ultimately lead to further special urological study which may clear up the diagnosis.

Perirenal infection of misplaced kidneys.—Perirenal infection of misplaced kidneys causes acute low back pain, usually not difficult of proper interpretation, but when associated with normal urinary findings and the pain is present over one side of the back only, some difficulty may be experienced in arriving at an early diagnosis.

I recall a patient presenting such a picture. He had a low grade fever, only moderate leukocytosis and no anterior tenderness on palpation. Exploration of a previously diagnosed ectopic kidney revealed a localized area of suppuration behind the kidney, which was lying over the sacral promontory.

Renal calculi.—With renal pelvic stasis and infection, stone formation is apt to follow. Sizable impassable stones produce obscure local pain, often referred anteriorly, but sometimes posteriorly only. The same may be said of stone in the lower third of the ureter if it has been impacted for a long period and has produced ulceration of the ureteral mucosa. Patients with stone at or below the sacral promontory do not present much of a problem in diagnosis, as an ordinary roentgenogram of the symptom producing area usually visualizes the trouble and further urologic study easily localizes it.

Renal neoplasm.—Renal neoplasm, not in contact with the renal pelvis, may develop to a large size without producing symptoms of any kind. This added weight may result in varying degrees of renal ptosis. I have seen such kidneys pulled down below the sacral promontory, actually to a pelvic position. Obviously, then, due to pressure on adjacent structures or infiltration of these local tissues, a local pain may be produced—frequently a unilateral low back pain.

While the urinalysis in such cases may be normal, palpation reveals a pelvic mass which requires visualization of the upper portion of the urinary tract for complete interpretation. A neoplasm of a normally placed kidney with metastasis to bone, while not usually a difficult problem, may be the cause of some confusion.

In the summer of 1939 I saw a man, 48 years of age, who had lost thirty pounds of weight and presented no further symptoms than marked tenderness and excruciating pain over the upper aspects of the right sacroiliac synchondrosis. No mass or abnormality could be detected over this area. A large tumor mass could be palpated in the right kidney region. Subsequent pyelographic study revealed a renal neoplasm and bone metastasis. The metastasis was shown by roentgen ray to be only in this painful area of bone.

Bladder lesions.—Pain produced by bladder lesions does not concern us here, except in a very indirect way when a bladder neoplasm partially obstructs an ureteral orifice, resulting in upper urinary tract dilatations, as previously noted. Similar situations prevail in congenital or acquired stenosis of the ureteral orifice within the bladder, with or without the presence of ureterocele. These lesions, however, usually present localizing symptoms as well, which result in cystoscopic examination of the bladder and discovery of the probable cause.

Genital Infections

Diseases of the prostate and seminal vesicles produce a large majority of low back pain complaints which are concluded to be primarily urological.

The prostate and seminal vesicles are supplied by nerves, chiefly of sympathetic origin, derived from the hypogastric plexus. It has been shown that nerve fibers ending in the prostate and seminal vesicles arise all the way from the tenth dorsal to the third sacral cord segments and that it is possible for prostatic and vesicle pain to be referred to any point innervated by any of the corresponding spinal nerves.

For purposes of organization, diseases of the prostate and seminal vesicles may be considered to cause low back pain in three distinct ways: (1) by metastasis of infectious or neoplastic tissue from foci within the prostate and seminal vesicles; (2) by blood borne toxins from infectious foci within the prostate and seminal vesicles; and (3) by reflex nervous impulses originating within these structures due to intraprostatic or seminal vesicular pressure or adhesions. These possibilities all presuppose the presence of acute or chronic infection or malignant neoplasm in the prostate or seminal vesicles.

The incidence of prostatic carcinoma is high while carcinoma of the seminal vesicles is astoundingly low. On the other hand infections of the prostate are usually associated with similar infections of the seminal vesicles, but vesicle infections are many

times associated with a noninfected prostate. Not so many years have passed since such genital infections were all considered the direct result of gonococcal invasion, the specific organism having prepared the way for nonspecific invaders. It is very obvious now that a relatively small percentage of these chronic genital infections are thus acquired.

The anterior urethra normally harbors some thirty-odd species of bacteria in a saprophitic state. Congestion, trauma from instrumentation, including catheterization, as well as any devitalizing disease or condition such as physical, mental or sexual fatigue may result in activation of these organisms with a resultant genital infection. Descending infections from the upper urinary tract and metastatic infections from distanct foci likewise play an important part in the genesis of these genital infections.

Clinical observation has forced the conclusion that metastatic infection from the male genital glands is from the seminal vesicle only. This is well confirmed by the constant finding of specific seminal vesiculitis in all cases of gonococcal arthritis in the male. It is therefore apparent that complete investigation of these structures includes clinical palpation of both prostate and seminal vesicles and microscopic study of their expressed secretions.

Important factors in examination.—All physicians are not endowed by nature with a long index finger which greatly simplifies examination of the prostate, but all can, with experience, learn the feel of a normal gland. Minor degrees of abnormality, such as irregularities of contour, consistency and symmetry cannot be recognized regularly by those not familiar with the normal.

Seminal vesicles usually are not palpable, but under proper conditions for examination and with a definite understanding of their location, variable degrees of vesicle involvement can be recognized by palpation in the vast majority of patients. Induration of the wall over the whole palpable surface or any isolated part of it, fixation or even sensitiveness on pressure without other palpable findings are more than suggestive. Too often opinions of negative findings are given when, either through lack of knowledge of the pertinent possibilities of seminal vesiculitis or lack of physical necessities of the examiner, the seminal vesicles are not properly explored.

Examination of prostatic fluid alone does not make a completed test. Seminal vesicle fluids must also be included in the examination. While it is not generally possible to secure vesicle fluid alone by expression, it is readily recognized grossly as a gelatinous substance in contrast to a milky liquid from the prostate. These substances are collected on a slide for microscopic study, first as a fresh specimen and then after staining. In a fresh state deficiencies in spermatozoa as to number and motility are noted, as are pus cells, especially if in clumps. On staining, the number of pus cells and their segregation is noted, as is any appearance of bacteria. Bacteria are many times not seen or recognized but are usually present when pus cells are present and can only be recognized and identified by culture. This latter procedure is not usually necessary nor practical for ordinary clinical purposes. At times deficient spermatozoa without the presence of pus are noted. This finding alone is suspicious of infection and repeated examinations should be made.

In this connection it should be emphasized that relatively normal fluid findings on the first examination, with a deficiency in number or motility of spermatozoa, lack of an adequate number of fat bodies in the prostatic fluid, or suggestive findings on palpation should demand repeated examinations before the patient is discharged as free from infection. Under these conditions, as many as four or five such examinations at intervals of a week may be necessary before deep-seated infection is brought to the surface. Conversely, too rough or too severe stripping or too short an interval between strippings can temporarily produce pus cells in the fluids from otherwise normal prostates and seminal vesicles.

Symptomatology and diagnosis.—There are three definite areas of the back that may be involved and cause painful symptoms as the result of prostate and seminal vesicle infections. The most common area for either

an acute or chronic type of pain is over one or both sacroiliac synchondroses; the next most common is the low dorsal region; and the least common is the high dorsal region. These locations are important in the order mentioned, whether pain is caused by metastatic infection, by toxins, or is referred. It has been stressed that such backaches are more pronounced in the morning. Sometimes, on awakening and making motion, patients are very uncomfortable, but improvement is made on increased motion, and gradually, as the day proceeds, the pain is relieved.

The prostate and seminal vesicles are not urinary organs and produce no urinary symptoms unless obstruction or urethral irritation develops. The vast majority of patients have no such local symptoms and infection may be suspected only after local palpation or a complete urine examination, which may reveal a pyuria of varying degree. Even this important finding was lacking, however, in 35 per cent of a large series of patients.

The back pain is variously described by the patient as an ache, dull pain, soreness, stiffness, burning, a bearing-down sensation, a tired feeling or a dragging sensation. A characteristic of seminal vesicle produced pain is that the distress is immediately aggravated by pressure on the vesicle; likewise these pains may be reproduced by overdistention of the seminal vesicle by injection through a vasotomy incision or after catheterization of the ejaculatory ducts.

In metastatic infections to the back, definite areas of tenderness may be felt in accord with the symptoms, while roentgen studies may reveal nothing unless late changes have developed. If no tenderness can be elicited over the painful area of the back, the symptoms probably are referred. The outstanding therapeutic test is the almost immediate relief of reflex back pain caused by distended prostatic acini, from lack of drainage of infected materials, when drainage is established by adequate massage.

We now rarely hear the expression "railroad spine" which implied varying degrees of chronic disability, real or imaginary, following back strain from muscular effort. But we are at times asked to pass on similar conditions occurring in many types of industry. Not infrequently nonspecific genital infections are found which prove to be the cause of the chronicity of the back condition. Granted that a man with asymptomatic genital infection sustained a direct or indirect trauma of the back, this region is made susceptible to metastatic invasion by circulating products of the infectious focus. Important and interesting medicolegal problems are encountered under these conditions.

Treatment.—Regardless of the type of pain or by what method produced by the prostate and seminal vesicles, logical treatment demands proper drainage of the infected focus. If there are late resultant changes in the tissues of the back, orthopedic treatment should be concurrent. If the genital infection responsible for the early metastatic back condition is discovered before late changes have supervened in the back, resolution without these late changes may occur.

While surgical drainage of seminal vesicles has had an extensive trial, it has been found wanting and today there is no substitute for careful, intelligent, systematic massage for these conditions, with intervals of a week between treatments and pressure within therapeutic reason. Relief of painful symptoms may be immediate or so delayed as to cause discouragement, but patience by the doctor as well as the patient eventually results in important improvement. Obviously it should not be necessary to emphasize the necessity of continuing local treatment until the pus cells have been greatly reduced, active spermatozoa and normal amounts of fat bodies reappear in the expressed fluids, and metastatic or referred symptoms completely disappear.

When proper local treatment over a period of several weeks is not followed by adequate therapeutic response, as determined by improvement in metastatic or reflex back pains or by the feel of the prostate and seminal vesicles or the microscopic appearance of their expressed secretions, we should investigate more thoroughly for other foci of infection which may be primary to the genital infection. Emphasis should be placed here on

infected teeth, tonsils and sinuses. Eradication of infections in these structures is often rewarded by success in the management of genital infections which had previously resisted adequate local treatment.

Other Causative Factors

Allied conditions, not associated with genital infections, such as verumontanitis and small caliber stricture of the bulbous urethra, are infrequent causes of low back pain, but must be mentioned in passing. However, no difficulty in diagnosis should be encountered because of the ever-present accompanying local symptoms.

Emphasis should be placed on an increasing number of recognized urethral conditions in the female as a source of referred back pains. Recent clinicopathologic studies have revealed a vast array of chronic urethral conditions with a varied local and referred symptomatology, many times referred to the lower back, but with other referred and local symptoms which should remove any obscurity.

Scrotal contents should not be overlooked as a cause of back pain. Mistakes have been made by failure to palpate testicles, when the only symptoms were unilateral mid-dorsal back pain, caused by retroperitoneal glandular metastases from a small and locally asymptomatic testicular neoplasm. Observation and palpation of the scrotal contents with the patient standing may reveal a varicocele within a long atonic scrotum as a cause of a unilateral dragging sensation over the upper sacrum or lower dorsal regions.

Cancer of the Prostate

Carcinoma of the prostate, apparently increasing in incidence, maintains a correspondingly more important position as a cause of back pain as time passes. This apparent increase is probably due to better diagnostic understanding of the condition in general and not to an actual percentage increase; however, when 20 to 25 per cent of all cases of chronic bladder neck obstruction are caused by carcinoma of the prostate, its importance in this connection is apparent.

As in infections of the prostate and seminal vesicles, carcinoma of the prostate produces back pain in two well recognized ways, i.e., by reflexion of pain impulses from intraprostatic pressure and infiltrations and by metastasis to bone of the regions producing the pain. Metastases, for the most part, occur by the way of lymphatics which accompany the nerves; hence, a great number of obscure pains of the back and hips, and sciatica-like leg pains, may be produced with or without bone involvement.

It is the consensus of most observers that primary carcinoma of the prostate most commonly originates in the posterior lobe and reaches the urethra and bladder neck only after progressing, by infiltration, through the entire thickness of the lateral lobes. Early diagnosis, therefore, would not be made after urinary symptoms have appeared, but perhaps could have been made earlier by a careful rectal examination. At this point it is pertinent to state that perineural lymphatic metastases often occur long before urinary symptoms, and that urinary symptoms may never occur in some patients even after marked bony metastases are present.

It is at once evident that much depends on the interpretation of the findings on rectal palpation. One probably would not misinterpret a stony hard, irregular, fixed gland, but when it is understood that 50 per cent of these malignancies are associated with some degree of benign hypertrophy, local findings are at times not convincing. Minor degrees of change in consistency over different surfaces of the gland, indefinite deep nodules and thickening above the prostate, between the posterior surfaces of seminal vesicles, are findings commonly encountered which must be given due consideration in forming conclusions. The marked tendency for carcinoma of the prostate to produce bone metastases must always be kept in mind. Help in diagnosis from the roentgen ray may be conclusive.

Treatment of carcinoma of the prostate is outside the scope of this discussion. Attention should be called, however, to the fact that pain from metastases is best controlled by deep roentgen ray therapy. Satisfactory reduction or complete disappearance of the pain is frequently thus obtained. While this

therapy may bring only temporary benefit, repeated courses have given repeated recessions of pain and are well worth while in many patients. With intractable back pains, not satisfactorily controlled by roentgen ray therapy, intraspinal alcohol injections or chordotomy may be indicated in selected cases.

Postural Changes in Genitourinary Disease

Diseases of the genitourinary tract are prone to produce various types of pain, distress, uneasiness, fullness, burning and allied symptoms either of a local or referred type. These may be of such a minor degree that the bearer is not actually conscious of their presence, but he may unknowingly acquire fixed positions when walking or sitting or knowingly do likewise when these symptoms are apparent. Attention has been directed to this posture as a possible cause and certainly an aggravation of already present back distress. Emphasis should be placed on certain cases of hydronephrosis as a cause of such protection given the affected side while walking or sitting. Prostate and seminal vesicle infections at times cause patients to sit in a fixed position to remove pressure from the perineum. In acute prostatitis or seminal vesiculitis, this is a cardinal symptom, but it is present to a lesser degree, unconsciously perhaps, in some chronic infections.

Summary

In this discussion, brief mention has been made of the various diseases of the genitourinary tract which may have a bearing on low back pain. When genitourinary symptoms are not localized, the genitourinary system is frequently overlooked as a possible factor in the production of back pains. The accessibility of the male genital glands to adequate examination, and the frequency with which they are found to be a causative factor, should demand their consideration in the diagnosis of backache more often than is now the case. Conversely, long continued local treatment of genital conditions, without adequate clinical response of the backache, should indicate the necessity of detailed study of other structures including the back, if this has not been carefully done (as it should have been) at the outset of therapeutic management. Similar requirements are certainly indicated before a surgical procedure on any genitourinary structure is undertaken for the relief of back pain.

The multiplicity of local, general and focal conditions, which alone or in combination cause back pain, demands a full understanding and consideration of these possibilities before a decision is made to proceed in a surgical or nonsurgical direction. Neglect in this regard sometimes results, at the very least, in much loss of time to the patient, while the continuation of an active process makes for chronicity or even permanent disability.

4. Gynecological Aspect

By EUGENE CARY, M. D.
Chicago

LOW back pain is a symptom complex, not a disease. Caldwell[1] stresses the fact that in order to diagnose backache properly, a careful painstaking history must be made; this to be followed by a careful physical examination, in order that, by exclusion, the proper diagnosis may be reached. I agree with him heartily when he says that casual history-taking and a superficial examination has resulted too often in unnecessary pelvic surgery or periods of needless fixation of the spine in splints or plaster.

As this paper has to do primarily with the gynecological and obstetrical aspects of the picture, I shall confine my remarks to discussing the pain of visceral and what I choose to call physiological origin. Characteristics of such pain are given below:

(1) The pain may be sharp, agonizing, a "catch" or only a sense of weight.

(2) The pain is located in the midsacral region.

(3) It is aggravated during the menses.

(4) It is little affected by stooping or bending.

(5) It becomes aggravated upon palpation; i.e., pulling on the uterosacral ligaments with the uterus

in retroversion. (Incidentally, correcting a retroversion and introducing a properly fitting pessary will alleviate this type of back pain.)

In examining a woman for backache, make her point out with one finger the exact location of the pain, and, while doing so, have her define, in her own words, just what type of pain it is and in which direction it radiates. Then ask her how long she has been conscious of it and whether it is more severe at certain periods; i.e., during her menses or after she has been standing a considerable time (pelvic congestion). All of this information will guide you in placing the blame in the right spot.

Lynch[2] gives a list of causes producing low back pain which I shall briefly enumerate here:

Rectocele and cystocele, in the young.
Large uterine myomata.
Prolapsus of the uterus.
Uterine retrodisplacements.
Endometritis of ovary and cul-de-sac.
Pelvic cellulitis.
Ureteral stricture.
Faulty posture (muscular and nervous fat).
Carcinoma of the cervix and uterus.
Metastases from carcinoma of the cervix and uterus.
Spina bifida occulta.
Spondylolisthesis.
Coccygodynia.
Pregnancy.

The following may be added to the above list:

Internal hemorrhoids.
Fecal bolus in the rectum.
Carcinoma of the rectum.
Rupture of the symphysis pubis.

Collins[3] states that pelvic disease is responsible for only one-third of the backaches in women. The pelvic viscera are supplied by the second to the fourth sacral nerves and the hypogastric plexus of the sympathetic system, so that backache from pelvic disease is caused by direct pressure on the sacral nerves,—or by painful impressions that originate within the organs, are conducted by the sensory fibers of the sympathetic system to the central nervous system and are then referred back to the peripheral distribution of the second to fourth sacral segments.

Lynch[2] reports backache as a symptom in 49 per cent of 1,041 cases in which operation was performed for pelvic disease and Ward cites its occurrence in 50 per cent of a large series of similar cases.

Sacroiliac Strain

There is another low back pain that occurs in women to which I wish especially to call attention. It has interested me for a number of years and I have felt a keen sense of pleasure in being able to relieve this painful affliction almost instantly. This condition I consider to be a sacroiliac strain, or, in some instances, almost a subluxation of the sacroiliac joint. Epstein[4] agrees with me that one may acquire chronic sacroiliac sprain, which may give rise to typical sciatic scoliosis.

I believe there are two types of this condition; one in which the ilium has a tendency to slip upward on the sacrum, and the other in which the sacrum seems to be rotated forward into the pelvis. The individual in which we find this condition is apt to be of the stiller type, undernourished and frail. This type of low back pain gives a very typical history and an easily recognizable picture, when once called to attention.

Its onset is usually sudden. The pain begins in the affected sacroiliac joint and radiates down the thigh over the patella and even down over the instep. The pain is aggravated by stooping, and when pressure is applied over the involved joint.

If the subluxation is of the first type, the leg on the affected side will appear shorter than the one on the well side. This is determined by approximating the two internal maleoli, with the pelvis horizontally true. Also, the foot on the affected side has a tendency to rotate further in abduction. There is also a muscular spasm, if the foot is raised without flexing the knee.

If the subluxation is of the second type, there is no apparent shortening of the leg on the affected side; in fact, it may appear slightly longer. However, do not let this deceive you, for further examination will convince you that it is purely a sacroiliac condition and that it is noninflammatory. The pain on pressure is in the upper sacroiliac

region and may radiate, in this instance, down the back of the leg.

How can these joints become mobile and what causes the ligaments to relax? Certain experimental evidence has come to light that would tend to make one believe there is a specific substance obtained from the corpus luteum which has the ability of relaxing these ligaments and making both the sacroiliac joints and symphysis pubis movable.

In 1932, Hisaw, Fevold and Leonard,[5] then of the department of zoology, University of Wisconsin, Madison, isolated a substance from the corpus luteum of the sow which they called relaxin. It has the ability, when injected into virgin guinea pigs, of causing spontaneous separation of the symphysis pubis and a relaxation of the sacroiliac ligaments.

von Massenbach,[6] in a study of the pelves of pregnant women, clearly demonstrated that a gradual widening of the symphysis occurred as the pregnancy continued, and he was the first to carry out investigations of symphysis widening during the menstrual period. In six out of nine cases, a plainly measurable loosening at the time of the menstrual period could be detected, and he concluded that in preparation for pregnancy considerable changes of position in the skeletal system are brought about.

Abramson, Roberts and Wilson[7] state they have observed a normal relaxation of the symphysis, beginning in the first half of pregnancy and progressing until the last three months; restoration is usually complete in from three to five months postpartum.

On x-ray study, Abramson noted that during the last two months of pregnancy, cystlike regions developed in the symphysis, and Eymer and Lang,[8] in a patient dying nine days postpartum, found in the symphysis a T-shaped cavity with expansile capacity. They concluded that not only is motion possible in the symphysis, but actual separation occurs during labor and birth.

I believe, from the foregoing accumulation of evidence, one is justified in assuming that we have definite proof there is, at times, relaxation in the ligaments and mobility in the joints of the pelvic girdle, so that during these periods, any motion transmitted to the sacrum and producing a sudden change in the direction of the force, will cause enough "slipping" to exert a strain or tension on the surrounding ligaments.

Treatment

For these women with painful sacroiliac joints that come under this classification, diagnosed as hereinbefore described, I have devised a series of manipulations. The maneuvers, carried out as one would reduce a dislocated shoulder (placing the joint in the position in which it was when dislocation occurred and then reversing the force) have given excellent results.

Rockey[9] emphasizes a fact I have found out from experience, namely, that in order to relieve these low backaches there must be a restoration of the normal lumbar curve. This is accomplished by placing pads beneath the back. I have also found very useful the introduction of a board (6 inches wide) across the bed underneath the mattress. This board is placed at such a level that it will contact the patient just above the sacrum, thus exaggerating the lumbar curve. In some instances this treatment alone has been enough to clear up the condition.

Cox[10] discusses the types of manipulation used by Goldthwait, Young, Hatch, Magnuson and himself for correcting these subluxations. I shall enumerate at this time, however, only the ones I have developed which are different than any of the others.

The manipulation used in the first type of subluxation previously discussed, namely, a slipping upward of the ilium, is as follows:

The patient is placed on her back on a hard top table with a pad in the lumbar region. Next the internal maleoli are approximated to determine the amount of shortening. At this time the patient is asked to grasp a support at the head of the table and completely relax the leg muscles, especially the adductor group. Now the ankle is grasped and swung outward about 40 degrees and upward 10 degrees. Firm traction is applied. This will elicit some pain in the affected joint. Gradually relax the tension and, as the patient relaxes, give a sudden jerk. If the reduction is not complete, repeat

the maneuver. If the internal maleoli seem approximated then set the joint by forcefully raising the pelvis from the table two or three times, grasping it with the tips of the fingers under the sacroiliac joints.

The manipulation for the condition in which the upper part of the sacrum has rotated forward is as follows: Place the patient upon her side facing the operator with the affected side uppermost. The top leg is bent over the table and firmly flexed by placing the foot between the knees of the operator. Now grasp the sacroiliac joint with the tips of the fingers and, with the other hand against the chest wall, gently rock the spine backwards and forwards until reduction occurs.

One must realize that when these ligaments are relaxed a simple reduction will result in only temporary relief. The pelvis must be maintained in a "fix" until the ligaments have again become firm.

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5. Orthopedic Aspect

By EDWIN W. RYERSON, M. D.

Chicago

FORTY years ago when a patient had a pain in the lower part of his back, the diagnosis and the treatment were easy and simple. The doctor called it lumbago, put him to bed and ironed out the pain with a hot flatiron. Nowadays, the case is very different. There are so many causes and explanations of low back pain that it would take a long time to consider them all in a thoroughly scientific manner, from the orthopedic standpoint alone. In this paper, therefore, only the more common types can be described.

In general there are two broad classes of low back pain: (1) those which occur rapidly, as the result of injury or excessive stress or strain; and (2) those which come on gradually as the result of faulty mechanics, congenital anomalies or active pathological conditions.

Pain of Rapid Onset

Sprains.—In the first class are the simple sprains of the actual joints of the vertebrae, occurring while lifting a heavy weight, pushing up a window which sticks and then suddenly gives way, or striking savagely at a golf ball or a base ball. A sudden, severe pain occurs which often disables a strong man completely. This injury is probably a sprain or a wrench of the small articulations of the vertebrae, which are true joints and are not the large intervertebral spaces. These joints are situated behind and lateral to the bodies of the vertebrae; they have definite capsules and true cartilaginous joint surfaces; and they can be sprained or strained in the same manner as an ankle joint or a wrist joint. Patients with this type of injury recover in ten or twelve days with rest and heat therapy.

Sometimes a sacroiliac joint can be sprained in the same way and even be slightly displaced or subluxated. Such a joint may be replaced by manipulation with immediate relief. It is important, however, to perform such manipulations with great care, because of the danger of causing an

extrusion of an intervertebral disc, with resultant paralysis.

The differential diagnosis between a lumbosacral and a sacroiliac lesion is sometimes very difficult, as in both conditions there may be irritation of the sciatic nerve, with radiation of pain down the thigh and calf. The best test for sacroiliac disturbance is that described by Gaenslen. If this test is negative and if a narrow belt buckled snugly around the hips just above the trochanters fails to give relief, the trouble is definitely not in the sacroiliac joints. X-ray examination in cases of sprain of the lumbosacral and the sacroiliac joints is never of much value, and, so far as I know, no actual pathological evidence of these lesions has been recorded in the literature, probably because no one ever dies from such injuries.

These sprains and strains occur more frequently in persons who have rheumatoid arthritis, osteoarthritis, or congenital anomalies in the lumbar vertebrae, but, under sufficient stress, they sometimes occur in normal individuals.

Compression fractures.—Compression fractures of lumbar vertebrae may be caused by comparatively slight injury, especially in elderly people whose bones have become decalcified because of improper diet or parathyroid dyscrasia. I have seen such fractures occur from lifting a weight, from being jarred in an automobile, and from sitting down unexpectedly on a floor. Lateral x-ray films should always be made in such cases.

Extrusion of an intervertebral disc.—The most dramatic chapter in the story of spinal pathology has been unfolded during the last ten years. The intervertebral discs, which had formerly been regarded as harmless, useful rubber pads between the vertebral bodies, have now been revealed as public enemy number one. Not only do they punch holes in the flat epiphyseal plates of the vertebrae, but they become pushed out backward into the spinal canal and press upon the cord or the cauda equina or the nerve roots at the side of the canal. They may cause back pain, radicular pain and sciatica, and even complete paraplegia. A spinal block may be found, and the total protein of the spinal fluid may rise, but not invariably, to more than 45 mg. per 100 cc. In some of the surgically treated cases the nucleus pulposus has been found extruded; in others, the dense fibrous annular portion of the disc is extruded.

In 70 per cent of Barr's surgical cases there was pain in the lumbosacral region, probably due to the local irritation of the ruptured disc, and in 95 per cent there was pain in the distribution of the sciatic nerve. The only distinctive *symptom,* not always present, is severe pain on sneezing or coughing, and even this may occur in some other conditions. The only distinctive *sign* is the appearance of a "filling defect" in the column of lipiodol injected into the dural sac and seen in the x-ray films.

For twenty-five years we have been performing operations in many cases of low back pain, in my clinics, to produce a bony ankylosis of the lumbar vertebrae to the sacrum, when it seemed evident that a mechanical instability or an arthritic disturbance was causing the pain. The x-ray films may show an enlargement of a fifth lumbar transverse process, with a joint between it and the sacrum, that is, a unilateral sacralization of the fifth lumbar vertebra, which often causes back pain; a congenital defect of the articular processes may be present; or the fourth or fifth lumbar vertebra may be slipping forward over the vertebra beneath, because of a defect or a fracture of the base of the vertebral arch, that is, spondylolisthesis. All of these different conditions are readily relieved by the operation of spinal fusion, which is best performed by the Hibbs method with the addition of a tibial bone graft laid on each side of the spinous processes, upon the laminae.

In many other cases in our series, however, the diagnosis was not at all certain, and yet it seemed evident that the stress and strain of movement and of weight-bearing were the factors producing the pain and disability in the lumbosacral region. Perhaps there was too much lordosis in this region, hollowing the lumbar curve and causing the lumbosacral interspace to be nearly vertical instead of nearly horizontal. The spinal fusion operation is highly successful in these conditions, because it transfers the strains

and stresses from the mechanically imperfect lumbosacral joint to the perfectly normal joint above.

Such cases properly belong in the second classification of low back pain, where the condition is not due to sudden injury, and yet the picture may be confused because of recurring attacks of pain and disability, with complete freedom from pain during remissions.

It is quite probable that some of these patients, operated on under various diagnoses, were really suffering from the results of extrusion of an intervertebral disc, and were actually cured by the spinal fusion operation. It is easy to understand why this is possible, because the extrusion of a disc is caused by a forcible forward flexion of the spine, and in many cases the extruded disc undoubtedly recedes back into the intervertebral space, at least temporarily, when the spine is extended backward. This explains the complete remission of symptoms in many cases where extrusion has later been confirmed by laminectomy.

If, then, during a remission, the spine is fused by operation, there can be no flexion movements to force out the intervertebral disc, and the patient will remain permanently relieved.

It would, therefore, be a perfectly sane and rational proceeding to perform a fusion operation instead of the more difficult and more dangerous laminectomy in those cases of disc protrusion where definite remissions occur, provided the fusion is done during a complete remission.

When the operation of laminectomy is performed for extrusion of a disc, it is important to have the patient on a table where the spine can be flexed and extended during the operation, because the disc may retract after the canal has been opened and may not be detected. When the spine is flexed, the disc may protrude, be easily seen and removed.

It is evident, from recent literature, that in cases where no other explanation of low back pain can be found, we shall be forced to inject lipiodol as a routine procedure. The injection of air instead of lipiodol has been done by several operators, but I have not been able to read the x-ray films with sufficient confidence to make me willing to abandon the lipiodol.

Pain of Gradual Onset

Let us now consider some of the other causes of low back pain which are not due to actual acute injury.

Static and inflammatory causes.—First among these come the static causes, such as exaggerated lumbar lordosis due to bad posture, or to high-heeled shoes. The treatment of these conditions is easy when the cause is recognized. Next come inflammatory conditions, such as myofascitis and fibrositis, the origin of which is obscure and perhaps rheumatic. Injections of novocain or some of the newer drugs may be curative.

Common pathologic causes.—Tuberculosis of the spine may occur at any level from the axis to the sacrum, and at any age from infancy to senility. Its symptoms come on gradually, and children rarely complain of pain until the disease is well advanced. Even then the pain is usually felt in the front of the chest or the abdomen rather than in the back. Older individuals, however, complain of pain in the back, which is always relieved by lying down on a flat bed. This is one of the most important differential signs between tuberculosis of the vertebrae and metastatic carcinoma, because the back pain in carcinoma is not relieved by recumbency. Roentgenography furnishes important aid in differential diagnosis: in tuberculosis, the intervertebral disc is usually flattened and destroyed early in the disease; in carcinoma the disc resists destruction long after the bone of the vertebra has been visibly invaded.

Acute and chronic osteomyelitis as causes of low back pain will not be considered in this paper.

Fibrous tumors under the skin in the sacral regions may cause pain, and have been successfully removed by operation. Cord tumors, extradural and intradural, cause pain, and fortunately usually cause peripheral nerve symptoms and signs which lead to their localization. The advice of the neurologist is of great value in these cases.

(Continued on page 492)

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« « « EDITORIALS » » »

99th ANNIVERSARY MEETING, STATE MEDICAL SOCIETY OF WISCONSIN
September 18, 19 and 20, 1940, Milwaukee

Reports to Insurance Companies

"I am to provide such reports to the insurance companies as may be reasonably necessary."

EACH member of the State Medical Society who applies for listing under the open panel agreement, wherein injured employees are authorized to have free choice of physician, subscribes and agrees to the above statement which appears on his application blank for listing under the open panel agreement.

The responsibility of physicians in rendering treatment to injured employees under the Workmen's Compensation Act is direct to the employees and the employers. The employers, through their insurance companies, have a definite responsibility to their employees, imposed by statute.

Unless the employers or their insurance companies have before them information as complete as possible concerning each compensation case, it is exceedingly difficult for them to fulfill their obligations under the Compensation Act and make it humanitarian in its application and operation. Upon the promptness of physicians in furnishing the insurance companies or employers with medical reports concerning injured employees under their care, depends the speed with which the claims are handled. If the reports are not made promptly, employees do not receive their weekly payments for wage loss and, in many instances, the prompt and proper settlement of claims is prevented.

As previously stated,* the open panel agreement is a voluntary mutual agreement between an extremely high percentage of the insurance carriers in Wisconsin and your Society. The purpose of the plan is to provide the injured employee with the care of

* See The Journal for Dec., 1939, p. 1046, and p. 482 of this issue.

his own family physician; through him, to provide that high quality of medical care which has characterized the profession in Wisconsin; and to make still more humanitarian the operation of the Workmen's Compensation Act. The success or failure of the open panel agreement depends on the wholehearted, sincere cooperation of each member of the Society who elects to participate. The spirit of the entire society and the manner in which the responsibilities are met are, of course, but the sum-total of the individual physician's spirit and conduct under the agreement with the individual insurance companies.

When requested to furnish reasonable reports concerning the facts of an industrial injury, the treatment being followed and the progress and prognosis in a given case, members of the Society are urged to forward such information without delay.

As the statement quoted above indicates, members agree to supply only such reports "as may be reasonably necessary." Should any member participating in the open panel agreement feel that unnecessary demands are made on him, he may make his thoughts known to the Conference Committee on Open Panels in an informal letter, and he is assured they will receive the studied consideration of the physicians and insurance company representatives constituting the conference committee.

"Just Nervousness"

THESE are trying times for our people. War news, and radio and press discussion of our economic and defense position in a rapidly changing world, heighten the tension under which large numbers of our people work.

We sense that increasing numbers, possibly because of this heightened tension, are seeking the services of medicine for ills that sometimes have no discernible organic basis.

Under such conditions, may we venture to remind our fellow members that a light dismissal with the words, "It's just nervousness," is an action little understood by the average patient. There are other words and other ways in which to convey the thought to the patient that will result in a lessening of the tension and an understanding of what it produces.

We urge that such ways and words be sought and used with care.

THE PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association advocates:

1. The establishment of an agency of federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

. . . . THE PRESIDENT'S PAGE . . . .

"Turn Boys, Turn—We're Going Back"

—*PHIL SHERIDAN.*

A WAR is going on in Europe. It and its outcome may have a sobering effect upon our thinking. Previous to the outbreak of this war, England and France, as well as other democracies, turned their legislative halls into debating societies, and out of them poured a "liberalism" which knew no bounds. Their people generally toyed with fantastic ideas which smelled of communism and yet were never quite that. Bizarre ideas, with paternalism in the foreground, sapped their strength, took the vitality that had previously existed under what we term a democratic form of government. It appears that they failed to notice several of their neighbors, who—instead of flirting with communism—put it into a very real and actual practice and did so to such an extent that the individuality of their citizens was effaced. The struggle in Europe today is that of Totalitarianism versus Democracy.

One cannot play marbles and go swimming at the same time.

Here in America, where we have followed the teachings and the philosophy of Europe for some 300 years, we find the same thing. Lately we have occasionally left the high bench of Democracy to puddle about with social experiments that tend to regiment our people. And, through it all, when some doubters arose, the government put a finger to its lips and said, "No, no, papa knows best." For the past several years we have struggled toward the promised Utopia, while most of those who were in a position to know better, and who should have lifted their voices in debate against it, acquiesced and dipped their hands in the same blood. We have lived in a huge fantasia and revolving in its many whirlpools and eddies there have been those who have climbed up on the log and expounded the craziest of ideas. Those whose propositions to solve our country's ills were the funniest, were accorded the front seat on the platform of the government.

The American people have an inherent weakness for listening to any college professor, whether he knows anything about a subject or not; and when he sets forth his views on the salvation of the world, the general populace advances with the great salaam accorded any first rate crystal gazer on the board walk of Atlantic City.

I cannot speak for others, but, as for me, I pride myself upon the fact that I can look through the crystal ball and see the dwarfed size of the man that holds it and his theories. Recently in this country every man and woman who had an idea was invited to bring it forth for trial in the great laboratory, and the laboratory has become to us the modern Tower of Babel. One of these men who was and is now a "gift" to the government from Wisconsin and who contributes largely to its thinking, said in testifying before a senate committee, "Over a period of years the government gradually will come to own most of the productive plants in the United States." Here was a man, himself an officer of the government, advocating out and out Socialism in the halls of Congress. Anyone who disputed these men or raised even a hushed protest was put down as a reactionary.

Then in Europe an army invaded Austria and a great gasp arose as Czechoslovakia, Poland, Finland, Norway and Denmark fell in quick succession. But the greatest gasp of all came after the invasion of Belgium and Holland. Witness the mad scramble in America. Overnight there came demands for rearmament and national defense; cries arose from our educators for the teaching of National Unity.

After all we can still bank on our people to come forward in this crisis and get back to the fundamentals of national thinking upon which this nation was founded. Until this emergency is over, there will be an abandonment of many of the "funny" ideas of socialism that plagued us in the immediate past. Some of those who were the loudest exponents of change will become the most rabid of hysterical witch hunters of the fifth column. Ever since gunpowder was invented it has always been the unloaded gun that has gone off and killed somebody. Many of our citizens in prominent walks of life, as well as the loafers around the court house, have fondled the unloaded gun for a long time.

What we need in this country today is some clear thinking. We need the help and advice of those in position to lead, to get us through this labyrinth. It can be done and it will be done; and the froth that has boiled up at times on the merry-go-round will jell.

In this program the physician, long the family counselor, can do much to stabilize thought and to quiet the hysterical and the frightened in the troublesome days to come. I know full well he has been more or less driven into retirement by the crystal gazers but this is the time for him to reassert himself for the public good. Detour around the crystal gazer, or better still knock the ball out of his hands, but keep on. The trouble in the immediate past has been the attempt to marry decent constructive thought to the theories of "pinks," controlled masses and the aforementioned crystal gazers. The resulting child is a hybrid, neither fish nor fowl. The effort is no more possible than that to weld the wooden handle to the pewter spoon, to make the lion and the lamb lie down together or to make boon companions of the spider and the fly—as Col. Henry Watterson remarked twenty years ago.

* * *

"Away with Shakespeare and his description of the human emotions. He offends every moral law of the Decalogue. My idea of a good joke is to sit upon my own hat."

—*OLIVER CROMWELL.*

R. G. Arum

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. Frank W. Pope, Racine, President
Mrs. Donne F. Gosin, Green Bay, President-Elect
Mrs. Thad W. Ashley, Kenosha, Vice President
Mrs. Homer M. Carter, Madison, Recording Secretary
Mrs. Charles E. Constantine, Racine, Corresponding Secretary
Mrs. Edwin P. Bickler, Milwaukee, Treasurer
Mrs. William M. Jermain, Milwaukee, Parliamentarian

COMMITTEE CHAIRMEN

Archives—
Mrs. Cornelius A. Harper, Madison
Convention—
Mrs. Eben J. Carey, Milwaukee
Finance—
Mrs. Arthur J. McCarey, Green Bay
Hygeia—
Mrs. Irenaeus N. Tucker, Racine
Organization—
Mrs. Ernest S. Schmidt, Green Bay
Philanthropic—
Mrs. Edgar F. Andre, Kenosha
Press and Publicity—
Mrs. Arnold S. Jackson, Madison
Program—
Mrs. James C. Hassall, Oconomowoc
Public Relations—
Mrs. Ira F. Thompson, Racine
National Exhibit (Special Committee)—
Mrs. E. Lee Lochen, Waukesha

Report of Nominating Committee

A meeting of the Nominating Committee of the Woman's Auxiliary to the State Medical Society of Wisconsin was held on May 3, 1940 at the Hotel Schroeder in Milwaukee. The following members were present:

Mrs. W. E. Buckley, Racine, *Chairman*
Mrs. R. E. Fitzgerald, Milwaukee
Mrs. S. J. Briggs, Madison
Mrs. R. E. McDonald, Milwaukee
Mrs. R. B. Dryer, Poynette

A slate of officers was prepared to be presented at the state meeting in September, and the following delegates and alternates to the national convention were elected:

Delegates:

Mrs. H. M. Caldwell, Columbus
Mrs. C. E. Pechous, Kenosha
Mrs. F. W. Hammond, Manitowoc
Mrs. W. M. Jermain, Milwaukee
Mrs. A. S. Kult, Milwaukee
Mrs. G. J. Pugh, Milwaukee
Mrs. L. O. Simenstad, Osceola
Mrs. H. A. Jegi, Galesville
Mrs. O. J. Hurth, Cedarburg
Mrs. A. G. Sullivan, Madison

Alternates:

Mrs. J. W. MacGregor, Portage
Mrs. L. W. Gregory, Manitowoc
Mrs. R. L. Simenson, Valders
Mrs. J. G. Taylor, Milwaukee
Mrs. G. E. Thill, Milwaukee
Mrs. R. G. Arveson, Fredric
Mrs. H. C. Caldwell, St. Croix Falls
Mrs. R. K. Irvine, Manawa
Mrs. W. A. Werrell, Madison
Mrs. H. W. Virgin, Madison

Respectfully submitted,
ETTA C. BUCKLEY,
Chairman, Nominating Committee.

A Message From the Auxiliary President

To the Members of the Auxiliary:

Now that vacation time is coming for many of our county auxiliaries, would it not be well to keep in mind the purpose for which we are organized? Summer months slip away quickly and fall meetings are resumed. What about the health education program for the year in your county? Has this received your attention or is it on the fall program?

The state chairman of public relations, Mrs. I. F. Thompson, asked me to remind you "that the clubs and P.T.A.'s will soon be working on their programs for the fall season. Please try to interest them early in putting on at least one health education program." She will gladly repeat the information previously given on sources for speakers and advises you "to keep after the members of your own county medical society for talks, until in self defense they form a speakers' bureau."

The Woman's Auxiliary to the Racine County Medical Society had such a meeting in April, the attendance being between 250 and 300 lay persons. Heads of clubs and other organizations having health programs were invited, with a guest privilege. It was work, of course, but pleasant and profitable work. The chairman, Mrs. E. W. Schacht, and her efficient committee felt well repaid when it was over. Mr. G. B. Larson, assistant secretary of the State Medical Society, was our speaker, and as an added attraction, there was a musical program and tea. From notes of appreciation received afterward and the expression that we might at some time repeat this event, it would seem that the general public is much interested in health education.

National convention plans sound both interesting and exciting. I hope many of you will attend and enjoy the various activities that have been arranged for you. Plans for the state convention in September are also well under way, and Mrs. E. J. Carey, convention chairman, promises to keep you busy while in Milwaukee. Plan to come—we want to see you.

MRS. F. W. POPE,
President.

Dane

The Woman's Auxiliary to the Dane County Medical Society met for a one o'clock luncheon on May 8 at the Lake View Sanatorium, the hostesses being Mesdames W. C. Reineking, J. G. Bohorfoush, H. A. Keenan, L. V. Sprague, and J. T. Sprague.

A short business meeting was held. The nominating committee for the coming year was appointed, Mrs. N. A. Hill of Madison being chairman. Assisting her are Mrs. B. I. Brindley and Mrs. F. W. Kundert, both of Madison.

Among Wisconsin women who will serve on the National Board of the Woman's Auxiliary to the American Medical Association is Mrs. G. H. Ewell of Madison. Mrs. Ewell has accepted the invitation of the president-elect, Mrs. V. E. Holcombe, to be national press and publicity chairman.

Fond du Lac

"More education and less legislation is needed to maintain health advances already made in America," Dr. E. J. Carey, dean of Marquette University School of Medicine, Milwaukee, declared at a public lecture on "National and Individual Health" before 250 persons at the Hotel Retlaw in Fond du Lac on May 3.

The meeting was sponsored by the Woman's Auxiliary to the Fond du Lac County Medical Society as a part of its public relations program, and preceding the meeting Dr. and Mrs. Carey were dinner guests of the members of the Fond du Lac County Medical Society and its auxiliary.

Dr. Carey was introduced by Mrs. H. E. Twohig, president of the Woman's Auxiliary. Mrs. W. C. Finn was general chairman of the committee in charge of the meeting. Assisting her were Mesdames E. V. Smith, Jr., J. C. Devine, W. C. Wojta, D. W. Calvy, V. A. Toland, S. A. Theisen, S. E. Gavin, A. M. Hutter, L. J. Keenan, J. C. Yockey, and H. E. Twohig.

Kenosha

An interesting program was presented at the May meeting of the Woman's Auxiliary to the Kenosha County Medical Society at the home of Mrs. W. C. Kleinpell of Kenosha.

The program included dramatic readings by four high school students, the Misses Mildred Bjorn, Helen Wickland, Irene Bowman, and LaVerne Birchard. A talk was also given by Mrs. Mary Field in regard to the toy loan project.

Those presiding at the tea table were Mrs. A. L. Mayfield and Mrs. C. G. Richards. Assisting Mrs. Kleinpell in entertaining were Mesdames C. E. Pechous, Theodore Sokow, C. F. Ulrich, and L. H. Lokvam.

La Crosse

Mrs. J. C. Harman of La Crosse, secretary of the Woman's Auxiliary to the La Crosse County Medical Society, has reported that the annual meeting was held at the Eleanor Gund Nurses Home on May 17. The president, Mrs. E. H. Townsend, presided.

The annual reports of standing committees were indicative of the fine cooperation which has made this, the second year of the La Crosse Auxiliary, a success. Six new members have been added, making a total of forty.

The report of the nominating committee was unanimously accepted, and Mrs. F. A. Douglas was installed as president for the coming year. Mrs. Gunnar Gundersen was named as president-elect, and Mrs. J. C. Fox, secretary and treasurer. The delegates elected to attend the state convention in September are Mrs. Gunnar Gundersen as alternate for the president, and Mrs. J. C. Fox, with Mrs. J. J. Simones as her alternate.

Mrs. J. A. Evans, who is leaving La Crosse to live in Boston, was presented with a token of remembrance by the retiring president, Mrs. E. H. Townsend, on behalf of the auxiliary. Mrs. K. P. Ruppenthal of Bangor, accompanied by Mrs. Dowe of Bangor, sang "Oh, Come to the Fair" and "God Bless America."

After adjourning, members attended the tea at the Y.W.C.A. sponsored by the Ibsen Club of La Crosse for the benefit of the Norwegian war relief fund.

Manitowoc

Mrs. L. J. Moriarity, Mrs. G. A. Rau, and Mrs. R. E. Martin were hostesses to the members of the Woman's Auxiliary to the Manitowoc County Medical Society at a spring tea at the Century Tearoom in Two Rivers on April 18. Mrs. T. H. Rees of Manitowoc poured. Fifteen members were present.

The speaker of the afternoon was Lester Bentley, Two Rivers artist, who discussed the life and works of Pablo Picasso. His talk opened the way to an understanding of Picasso, particularly his later works which are difficult to appreciate. Mr. Bentley showed pictures to illustrate the different periods of Picasso's work.

Plans for the auxiliary's participation in the meeting of the medical societies of the fifth councilor district on June 27 were made at a luncheon on May 16 at the Maple Crest Sanatorium, Whitelaw. Mrs. A. F. Stueck, Mrs. L. W. Gregory, and Mrs. L. J. Moriarity were appointed by Mrs. T. H. Rees, president, to serve on the entertainment com-

mittee for the district meeting, when physicians' wives from adjoining counties will be guests of the Manitowoc auxiliary.

Miss Freda Breaker, superintendent at Maple Crest, was hostess to the members of the auxiliary at the luncheon and discussed the work being done at Maple Crest. After the luncheon she took her guests on a tour of the sanatorium and demonstrated the new x-ray equipment.

On June 19 the auxiliary will elect new officers, and Mrs. N. C. Erdmann, Mrs. L. D. Sobush, and Mrs. G. M. Hoffman were appointed to the nominating committee. Mrs. E. W. Huth of Mishicot and Mrs. T. H. Rees of Manitowoc, who with Mesdames F. W. and R. W. Hammond of Manitowoc attended the Sheboygan auxiliary meeting on May 1, reported on the meeting, at which Mrs. F. W. Pope of Racine, state auxiliary president, spoke. In concluding the business session, a donation of $34 was voted to the Women's Field Army for the Control of Cancer, and the members bought Citizenship Day buttons.

Milwaukee

The annual Mother's Day luncheon of the Woman's Auxiliary to the Medical Society of Milwaukee County was held on May 10 in the Green Room of the Hotel Schroeder. Maypoles in pastel colors decorated the tables, at which 145 members and guests were seated. At the speakers' table were Mesdames C. D. Partridge, R. E. McDonald and her mother-in-law, W. H. Studley and her mother-in-law, and R. D. Champney and G. H. Friedman and their mothers.

The president, Mrs. C. D. Partridge, welcomed the mothers. The president-elect, Mrs. R. D. Champney gave a toast to the mothers; the response was given by Mrs. Daniel Hopkinson, Mrs. Champney's mother. Before the regular program, Mrs. E. J. Carey, state convention chairman, announced the activities planned for this important event.

A musical program followed. Mrs. M. E. Gabor, music chairman, accompanied the guest artist, Mrs. Arlene Buckley Lazaar, soprano, in three well known songs, "You Who Have Yearned Alone," "In a Luxembourg Garden," and "Love is the Wind."

Mrs. R. D. Bergen, program chairman, introduced Mrs. Phyllis Higgins, who reviewed twelve best sellers. Particular attention was given to "Maud" by Richard Lee Strout, scenes from which were pantomimed by the following auxiliary members: Mesdames R. H. Feldt, Ervin Hansher, M. Q. Howard, D. H. Lando, Jr., and E. H. Rettig.

After this delightful entertainment the business meeting was held. Reports of the dance held on May 4 at the Wisconsin Club and the rummage sale on April 16 and 17, sponsored by the Hygeia committee, were given. The membership chairman, Mrs. G. J. Pugh, announced the following new members: Mesdames S. J. Hiller, Arthur Kovacs, S. R. Mitchell, W. S. Polacheck, P. J. Purtell, and J. P. Wild.

Mrs. R. E. McDonald, chairman of the budget committee, enlightened members regarding the auxiliary's financial disbursements. This information was essential as one of the points in consideration of the revision of the constitution was increased dues. Proposed amendments to the constitution and by-laws were discussed and voted upon favorably.

The meeting concluded in an appropriate manner. Mrs. T. M. Northey, social chairman, presented corsages to the oldest and youngest mothers present: Mrs. Thomas Gardner, mother of an auxiliary member, Mrs. P. M. Currer, and Mrs. T. M. McCormick, a guest and the youngest mother present.

The study group met preceding the luncheon, eighteen women being present. The members are looking forward with intense interest to continuation of this particular activity in the ensuing year.

Polk

The members of the Polk County Medical Society and its auxiliary were pleasantly entertained by Dr. R. G. Arveson, president of the State Medical Society of Wisconsin, and Dr. W. A. Andrews at the M. E. Parish Hall in Frederic on April 18 at a seven o'clock dinner. Following the dinner Dr. Arveson showed movies of a recent trip that he and Mrs. Arveson had made in eastern Canada and the United States.

The auxiliary members then went to Mrs. Arveson's home for their business meeting. Mrs. D. A. Maas of Webster was elected treasurer to fill a vacancy in that office.

Portage

A card party was held recently at the home of Mrs. W. F. Cowan of Stevens Point under the auspices of the welfare committee of the Woman's Auxiliary to the Portage County Medical Society. Mrs. S. R. Miller was chairman of arrangements. Snapdragons were used in decorating the tables for a dessert luncheon, which was followed by bridge. Honors at auction were awarded Mrs. Frank Metcalf and Mrs. W. A. Gramowski, while the contract winners were Mrs. James Briselden and Mrs. Edith MacMillan.

The purpose of the party was explained by Mrs. Alice Eccleston, superintendent of nurses at River Pines Sanatorium, who was introduced to the group by Mrs. T. L. Harrington, president of the auxiliary and wife of the medical director at River Pines Sanatorium. Mrs. Eccleston discussed the work at the sanatorium and told of the need of warm pajamas and sweaters, magazines, books, and playing cards for patients unable to purchase them.

Rock

The twenty members of the Woman's Auxiliary to the Rock County Medical Society who gathered at the Hotel Hilton in Beloit on April 23 were delightfully entertained by Mrs. James Wolfe who gave a sympathetic and artistic reading of "No

Time for Comedy," the Katherine Cornell dramatic success. The tables were attractively decorated with iris, yellow roses and jonquils, furnished by Mrs. H. E. Kasten. It was announced that Mrs. F. W. Pope of Racine, state president, would be the speaker at the May meeting.

Sheboygan

A message from the state president, Mrs. F. W. Pope of Racine, featured the May luncheon meeting of the Woman's Auxiliary to the Sheboygan County Medical Society held on May 1 at Benedict's Heidelberg Club, Sheboygan. Mrs. Pope, speaking informally, confined her talk to the state and national activities of the auxiliary.

The program was opened with two piano selections by Joanne Hertel, who played, "March Little Soldier," by Pinto, and "Sol Feggetto," by Bach, after which Romaine Phalen presented two readings, "Rehearsal," from the "Torch Bearer," by George Kelly, and "Motoring in the Nineties," by Cornelia Otis Skinner. The entertainment continued with two vocal numbers by Mrs. E. T. Hougen and Miss Ethel Harmelink, both of Oostburg, who sang "I Would That My Love" by Mendelssohn, and "Because You're You," by Victor Herbert. Mrs. Harold Te Ronde of Oostburg played their accompaniments.

Howard Jerving, bass soloist, contributed a group of three numbers, "The Dawn," "I Wait For Thee," and "Eagle," a composition written by an Indian. He was accompanied at the piano by Miss Ruth Ruppel.

Mrs. W. A. Ford, president, presided at the luncheon program.

Waupaca—Shawano

The Woman's Auxiliary to the Waupaca–Shawano County Medical Society was honored on May 7 at its regular meeting held in New London by the presence of the president of the Woman's Auxiliary to the State Medical Society of Wisconsin, Mrs. F. W. Pope of Racine.

The New London members arranged for a one o'clock luncheon at the Elwood Hotel. Sixteen members and three guests were present. Following the luncheon two vocal selections were given by the girls' trio of Washington High School and a reading "The Rest Cure" by Alice Stanley.

The president, Mrs. W. J. Irvine of Manawa, presided over the business meeting, and after various committee reports introduced Mrs. Pope who discussed the work being done in the auxiliaries throughout the State, stressing the importance of friendliness and sociability among the members. She also mentioned public relations and philanthropic work, the dissemination of information on health through "Hygeia," and the importance of attending the state convention in September.

Mrs. W. J. Irvine of Manawa and Mrs. E. A. Weller of Weyauwega are the delegates appointed to the state convention, and Mrs. L. G. Patterson of Waupaca and Mrs. L. W. Peterson of Shawano are the alternates.

Mrs. J. H. Murphy of Clintonville presented an attractive poster on "Cancer Crusade," which will be displayed by the Waupaca–Shawano County unit at the American Medical Association exhibit in New York.

Mrs. H. C. Schmallenberg of New London has recently become a member of the auxiliary.

A social hour of contract bridge followed the business meeting. On adjournment it was announced that the next meeting will be held in Clintonville on August 6.

Winnebago

The Woman's Auxiliary to the Winnebago County Medical Society entertained on April 29 at a delightful tea and afternoon program at the Mercy Nurses' Home. There were nearly one hundred guests present including members of the dental auxiliary, nurses from the hospital, and presidents of various leading civic groups in the county.

Mrs. R. H. Bitter, president, spoke briefly in greeting and explained that the purpose of the get-together tea was to acquaint the various civic groups of the county with the fact that the auxiliary, through its public relations committee, will supply speakers on health topics for their programs. Mrs. E. B. Pfefferkorn of Oshkosh, chairman of the public relations committee, has contacted a great many lay organizations, and she explained to the guests that the object of the medical auxiliary is to extend the aims and services of the medical profession to other groups which are looking for advancement in health and health education.

Mrs. W. A. Wagner, chairman of the program committee, introduced Mrs. L. C. Thomas, who opened the program with delightful vocal numbers. She sang "Winds in the South," by John Scott; "Rose Softly Blooming," by Spore; the "Bell Song," from "Lakme," and as an encore "American Lullaby," by Rich. Mrs. Dorothy Haven played her accompaniments.

Mrs. Nile J. Behncke, head of the Teachers College art department, as speaker of the afternoon, presented an interesting and helpful talk on "Home Decoration."

The tea table was centered with a bouquet of purple iris and white hyacinths. Mrs. T. D. Smith and Mrs. G. H. Williamson, both of Neenah, poured. Mrs. J. F. Stein of Oshkosh was general chairman of the event, and on her committee were Mesdames G. A. Steele, A. G. Koehler, E. F. Cummings, and H. A. Romberg, all of Oshkosh, and Mesdames G. R. Anderson of Neenah and P. T. O'Brien of Menasha.

Remember the annual convention in Milwaukee in September. Headquarters: Schroeder Hotel. Mrs. Eben J. Carey, chairman.

Society Proceedings

Ashland—Bayfield—Iron

The Ashland–Bayfield–Iron County Medical Society met on April 20 at the Menard Hotel, Ashland. Dinner was served at 6:30 and later a scientific program was presented. Dr. Walter P. Blount, Milwaukee, discussed "Bone Infections." Motion pictures were shown on the orthopedic treatment of poliomyelitis. Twenty-one physicians attended the meeting.

Barron—Washburn—Sawyer—Burnett

The Barron–Washburn–Sawyer–Burnett County Medical Society met on May 7 at the Land O' Lakes Hotel in Rice Lake. Following a 6:30 p. m. dinner, the following scientific lectures were heard: "Diagnosis and Treatment of Ano-Rectal Diseases," by Dr. W. A. Fansler, Minneapolis, and "Surgical Infection of the Kidney," by Dr. W. J. Carson, Milwaukee. Fifteen physicians were present.

In a business session, a committee was appointed to consider the organization of a woman's auxiliary to the society.

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society held its May 9 meeting at the Beaumont Hotel, Green Bay. A dinner, business session and scientific program were features of the event. In the business session the following resolution was passed:

WHEREAS, There is a growing tendency of the relief departments of the surrounding towns and villages to become progressively more conscious of medical relief expense; and

WHEREAS, There is a tendency of said relief departments to look to the organized medical societies for guidance in their programs of medical relief; and

WHEREAS, There has been a tendency in the past to depend upon bids alone to determine who shall take care of the indigent, which bids help to degrade the positions into cut throat competition, be it therefore,

Resolved, That the Executive Committee of the Medical Society shall, after thorough study of the average cost in caring for the indigent of any given town or village, name the reasonable figure covering medical and surgical care, advise the proper authorities of said figure and encourage applications by all who might be interested in the position. Be it further,

Resolved, That no member of the County Medical Society shall under-bid the prescribed figure under penalty of forfeiture of membership in the Society.

Dr. W. M. Kearns, Milwaukee, was the guest speaker on the scientific program. He spoke on "Pyelitis and Testicular Deficiency," illustrating his remarks with lantern slides and motion pictures. Forty-six attended the meeting.

Columbia—Marquette—Adams

The Columbia–Marquette–Adams County Medical Society met on April 16 at St. Mary's Hospital, Columbus, for a 6:30 p. m. dinner and scientific session. Dr. James Jackson of Madison was the guest speaker. He discussed "Open Reduction of Fractures." Twenty physicians attended the event.

Dane

Dr. Henry V. Bancroft, Blue Mounds, received the acclaim of 178 of his colleagues and friends, May 20, in Madison, when the Dane County Medical Society presented him with a plaque, bearing the following inscription:

"DANE COUNTY MEDICAL SOCIETY
MADISON, WISCONSIN
to
"HENRY VALENTINE BANCROFT, M. D.

"Whose 55 years in the practice of medicine in this county have enriched generously and deeply the lives of his thousands of patients as well as by precept, the lives of his associates in membership in this society;

"Whose long span of faithful service has encompassed the golden years of achievements in medicine;

"Whose every deed has upheld the ideals of medicine wherein the profession of medicine has for its prime object the service it can render to humanity, and

"Whose service ever has been given to all alike without regard to self or reward,—

"THIS SCROLL OF APPRECIATION
is dedicated

"By his associates in membership and in the fellowship of medicine on this 20th day of May, 1940."

Dr. Bancroft, who graduated from Rush Medical College in 1885 and is now 80 years of age, often traveled the twenty-five miles from his home to Madison on a supposedly fast train, the "Cannon Ball," to attend early meetings of the Dane county society, making the return trip on top of a box car on the midnight freight with a medical colleague who lived in Mt. Horeb. He has been a member of the Dane County Medical Society for fifty-five years.

Dr. Frank H. Lahey, Boston, was the main speaker of the evening. Others taking part in the dinner meeting program were: Drs. T. W. Tormey and C. A. Harper, Madison; Dr. R. G. Arveson, Frederic, president of the State Medical Society; and Dr. Ralph P. Sproule, Milwaukee, the State Society's president-elect.

Douglas

The Douglas County Medical Society at its April 4 meeting had as guest speaker Dr. Paul Barton of the Bureau of Investigation, American Medical Association, Chicago. Dr. Barton's topic was "Drugs." Forty-four members of the society and its woman's auxiliary, as well as several guests, attended the meeting and the dinner preceding it.

Eau Claire—Dunn—Pepin

The Eau Claire–Dunn–Pepin County Medical Society met on April 29 at the Hotel Eau Claire, Eau Claire, for a dinner meeting. Guest speakers on the program were Dr. W. A. Fansler, Minneapolis, who spoke on "Medical and Surgical Treatment of Hemorrhoids," and Dr. H. O. McPheeters, Minneapolis, who discussed "Treatment of Varicose Veins and Ulcers." A motion picture, entitled "Modern Combined Ligation and Injection Treatment of Varicose Veins," was shown. Forty-five attended.

Fond du Lac

Dr. Eben J. Carey, dean of Marquette University School of Medicine, Milwaukee, was a guest at the dinner meeting of the Fond du Lac County Medical Society and its woman's auxiliary on May 3. After the meeting, held in the Retlaw Hotel, Fond du Lac, Dr. Carey addressed a public gathering of some 250 persons on the subject, "National and Individual Health." The *Fond du Lac Commonwealth Reporter* quoted Dr. Carey as saying:

"Europe is sick today because, not only the political philosophy, but the quality of medical science has been lowered. There is no American at the present time who desires to be transplanted to Europe.

"There is no reason, therefore, to transplant a European system of compulsory health insurance or to salvage the system whose only outcome would be to destroy the physical and mental health of the individual and make him a slave of the state.

"Those who advocate compulsory health insurance do so dominantly through ignorance. It is this ignorance that the medical profession must overcome by co-operation with the public and by education."

La Crosse

The La Crosse County Medical Society met at the Grandview Hospital, La Crosse, May 7. Dr. Paul C. Bucy, assistant professor of neurosurgery at the University of Chicago, was the guest speaker of the evening. He discussed "Early Signs and Symptoms of Brain Tumor," and "Infectious Complications Following Swimming."

The La Crosse County Medical Society is assisting local groups in planning summer round-up clinics for the free examination of children who will enter school next fall for the first time.

Manitowoc

The Manitowoc County Medical Society held its April 18 meeting at the Catholic Center, Manitowoc, at 12 o'clock noon. Dr. E. L. Sevringhaus, Madison, was the guest speaker. He discussed "Obesity."

The Manitowoc County Medical Society honored two of its pioneer members, Drs. J. E. Meany and F. W. Hammond, at its meeting in Manitowoc, May 16. Dr. A. H. Heidner, West Bend, councilor of the Fifth Councilor District of the State Medical Society, praised the two physicians for their forty-two years of work in medicine. Both graduated from the Milwaukee Medical College in 1898. Dr. Meany started the general practice of his profession that same year in Manitowoc; Dr. Hammond located in Columbia county, opening his Manitowoc office in 1914.

Other speakers on the program were Mr. J. G. Crownhart, secretary of the State Medical Society; Dr. A. E. Rector, Appleton; and Dr. E. C. Cary, Reedsville, who acted as master of ceremonies.

Milwaukee

The Medical Society of Milwaukee County met on May 10 at the Milwaukee Athletic Club at 8:15 p. m. Dr. L. J. Van Hecke, Milwaukee, discussed "Laboratory Routine During the Use of the Sulfamides" and Dr. Alexander E. Brown of the Mayo Clinic, Rochester, Minnesota, spoke on "Sulfapyridine and New Compounds."

The last two lectures in the Society's postgraduate clinics on allergy were presented on May 7 and 14. The lectures dealt with clinical phenomena in allergy, and management and principles of treatment. Instructors for the postgraduate clinics were Drs. H. A. Heise, T. G. Randolph and T. L. Squier, Milwaukee.

The Medical Society of Milwaukee County assisted the Milwaukee Association of Commerce in May in presenting the Association's annual school of first aid. Speakers at the first session on May 6, were Dr. Harold E. Cook, Milwaukee, chairman of the first aid committee of the Society, and Dr. G. E. Meloy, Milwaukee. In announcing the school, the Association stated that injuries cost Milwaukee employers about $2,500,000 a year and that the Association's safety service includes the training of 14,000 employees annually.

Outagamie

The Outagamie County Medical Society held its May 16 meeting at the Conway Hotel, Appleton. Dinner was served at 6:30 p. m. On the program which followed Mr. J. G. Crownhart, secretary of the State Medical Society, Madison, discussed current problems of the medical profession and Dr. E. J. Zeiss, Appleton, spoke on "Conjunctivitis." Thirty-six were present.

Polk

Members of the Polk County Medical Society and its woman's auxiliary were the guests on April 18 of Drs. W. C. Andrews and R. G. Arveson, Frederic. A banquet was served to the group in the Methodist Parish Hall. In the course of a discussion on how to stimulate greater participation and interest in programs, it was decided that, at every other meeting, three members speak on a subject of their own choice. The time limit on these presentations, which will be followed by general discussion, is to be from five to ten minutes.

The Polk County Medical Society is cooperating with local health groups in offering a tuberculosis testing program.

Portage

The Portage County Medical Society met at St. Michael's Hospital, Stevens Point, at 8:15 p. m. on April 17. The following program was presented:

"What's New in Obstetrics"—Dr. V. A. Benn, Rosholt

"Toxemia of Pregnancy"—Dr. W. A. Gramowski, Stevens Point

"The Obstetric Forceps"—Dr. W. C. Sheehan, Stevens Point

Opening Discussion—Dr. E. P. Crosby, Stevens Point

General Discussion

The Portage County Medical Society cooperated with the Crippled Children Division of the State Department of Public Instruction, May 18, in presenting a field clinic for crippled children in Stevens Point.

Racine

The Racine County Medical Society met at the Waterford Woods Country Club on May 16, for an afternoon of golf and an evening scientific session. On the scientific program, Dr. R. B. Malcolm, assistant professor of surgery, University of Illinois, discussed "Tumor of the Neck," and Dr. Millard Tufts, Milwaukee, "Clinical Aspects of Electrocardiography." Following the meeting, lunch was served. Sixty attended the event.

Rock

The Rock County Medical Society met on April 23 at the Hotel Hilton in Beloit. The guest speakers were Dr. J. E. Gonce, Madison, who spoke on "Recent Advances in Pediatric Therapy," and Dr. F. M. Frechette, Janesville, who presented case reports and a discussion on "Erythroblastoma Fetalis." Forty physicians attended the meeting which Dr. O. V. Overton, secretary of the society, describes as a "very interesting and practical" one. Dr. E. C. Hartman, Janesville, was program chairman for the meeting.

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met on May 16 in Independence. Dinner was served at 6 p. m. and the following scientific program was presented:

Moving picture film, run by Dr. L. M. Morse, Neillsville, "The Appraisal of the Newborn."

Demonstration of home delivery equipment by Dr. F. T. Younker, Galesville.

Nineteen physicians attended the meeting.

Winnebago

The Winnebago County Medical Society met on May 2 at the Sunny View Sanatorium, Winnebago. Dinner was served to the physicians by members of the Sanatorium staff. Dr. William H. Oatway, Jr., Madison, was the guest speaker of the evening. He discussed "Modern Collapse Therapy in Tuberculosis." About thirty members of the society were present.

Section on Radiology

The Section on Radiology of the State Medical Society of Wisconsin, at its meeting in La Crosse, May 17–18, elected the following officers for the ensuing year:

Chairman—Dr. T. J. Pfeffer, Racine

Vice-Chairman—Dr. F. C. Christensen, Racine

Secretary-Treasurer — Dr. Russell F. Wilson, Beloit

The program of the May meeting, directed by Dr. S. A. Morton, Milwaukee, was published in the May issue of THE JOURNAL. It included presentations by prominent radiologists throughout the State and two lectures by Dr. H. Dabney Kerr of Iowa City, Iowa. In 1941 the Section will meet in Racine.

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society met on April 30 at the University Club, Milwaukee. Dr. William E. Grove, Milwaukee, was the main speaker, discussing "Vertigo." Following his presentation, there was general discussion, opened by Drs. D. A. Cleveland and J. L. Garvey, Milwaukee.

At its May 28 meeting the society had as guest speaker, Dr. Leon J. Saul of the Institute for Psychoanalysis, Chicago. His subject was "Emotional Settings of Some Attacks of Urticaria."

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society met on May 14 at the University Club, Milwaukee. Clinical cases were presented at 5:30 p. m. Dinner was served at 6 p. m., after which the following scientific program was presented:

"Blastomycosis of the Oesophagus." Report of a Case. Dr. Gerhard Strauss, Milwaukee

Discussion of Pathology by Dr. John Grill, Milwaukee

"Retrobulbar Neuritis." Report of 3 Cases. Dr. J. M. Molsberry, Milwaukee

"The Laryngological Aspects of Sporadic Infectious Mononucleosis." Dr. W. E. Grove, Milwaukee

Discussion of Pathology by Dr. John Grill

Discussion of Blood Picture by Dr. Fred Madison, Milwaukee

Ninth Councilor District

The Ninth Councilor District Medical Society of the State Medical Society of Wisconsin met in Stevens Point on the afternoon and evening of May 9.

The afternoon program, presented at River Pines Sanatorium, was as follows:

"Heart Disease," Dr. Francis Murphy, professor of medicine, Marquette University Medical School, Milwaukee.

"Recent Advances in the Surgery of Pulmonary Tuberculosis," Dr. John D. Steele, chest surgeon at Muirdale Sanatorium, Wauwatosa.

"Diseases of the Lungs," Dr. Oscar Lotz, executive secretary, Wisconsin Anti-Tuberculosis Association, Milwaukee.

In the evening, after dinner at the Hotel Whiting, further lectures were given, as follows:

"Tuberculosis in Alaska," Dr. J. A. Carswell, associate executive secretary of the Wisconsin Anti-Tuberculosis Association, Milwaukee.

"Indications for Bronchoscopy," Dr. John D. Steele.

"Non-Tuberculous Diseases of the Chest," Dr. Oscar Lotz.

"The Cause, Prevention, and Treatment of Coronary Disease," Dr. Francis Murphy.

Also participating in the program were Dr. Stephen Gavin, Fond du Lac, chairman of the Council of the State Medical Society; Dr. R. G. Arveson, Frederic, president of the State Society; Dr. H. H. Christofferson, Colby, councilor for the Ninth District; and Mr. George Crownhart, secretary of the State Society.

Dr. T. L. Harrington, Stevens Point, and members of the Portage County Medical Society were in charge of program arrangements.

In a business session, Dr. J. W. Monsted, New London, was elected president of the councilor district society, and Dr. Joseph F. Smith, Wausau, was reelected secretary.

Eleventh Councilor District

A special meeting of the Eleventh Councilor District of the State Medical Soceity was held in Iron River, May 24, at the home of Dr. Fred J. Johnson, Sr., councilor for the district. Mr. J. G. Crownhart, secretary of the State Medical Society, was the principal speaker. Preceding the meeting a 7 p. m. dinner was served at Olson's restaurant in Iron River.

Physicians present included the following: Drs. Fred G. Johnson, Jr., Thomas J. Doyle, Thomas J. O'Leary, William Schnell, L. W. Beebe, C. H. Mason, H J. Orchard, Victor E. Ekblad, and J. W. McGill, all of Superior; Dr. C. W. Lockhart, Mellen; Drs. H. F. Ringo and A. C. Krumpelbeck, Montreal; Dr. F. C. Jacobson, Washburn; Drs. R. O. Grigsby, M. L. Young, C. A. Grand, Frank D. Weeks, A. X. Kamm, A. H. Lamal, J. M. Dodd, Sr., of Ashland; and Dr. Fred G. Johnson, Sr., Iron River.

News Items and Personals

Wisconsin at the A. M. A. Session

Dr. Rock Sleyster, Wauwatosa, will open this year's session of the American Medical Association, the first to be held in New York City since 1917, and then will be succeeded as president of the Association by Dr. Nathan B. Van Etten, New York City. Dr. Sleyster will be honored at the opening general meeting, June 11, with a medal, in recognition of his noteworthy service to the medical profession.

A number of other Wisconsin physicians will also participate in the program.

Dr. Erwin R. Schmidt, Madison, will present a paper in the surgical division of the general scientific meeting, June 11, on "Problems Attending the High Mortality Rate in Appendicitis."

Dr. Francis D. Murphy, Milwaukee, will open discussion of a paper presented by two Mayo Clinic physicians on "Relation of Use of Tobacco to Coronary Disease," June 13, in the meeting of the Section on Practice of Medicine. And, on June 14, Dr. Murphy, with *Drs. H. L. Correll*, Wauwatosa, and *J. C. Grill*, Milwaukee, will present a paper before the same section, meeting jointly with the Section on Pharmacology and Therapeutics, on "Effects of Intravenous Solutions on Patients with and without Cardiovascular Defects."

Dr. W. E. Grove, Milwaukee, will open discussion of a paper, June 12, to be presented in the Section on Laryngology, Otology and Rhinology by Dr. H. A. Fletcher of San Francisco. The paper will deal with industrial aspects of ear, nose and throat practice.

Two Madison physicians will take part in presentations having to do with problems in anesthesia: *Dr. Ralph M. Waters* will talk on "Anoxia from the Anesthetist's Point of View," in the Section on

Pathology and Physiology, June 12, and will discuss a paper presented by two New York physicians, on "Studies on the Absorption of Carbon Dioxide from Anesthetic Mixtures," on the same day in the Session on Anesthesia. *Dr. Hubert R. Hathaway* will discuss a paper on "Anesthesia and Liver Injury," prepared by four physicians from Iowa City, Iowa, to be presented in the Session on Anesthesia, June 12.

A paper by *Dr. Hans H. Reese*, Madison, and W. F. Petersen, Chicago, on "Psychotic and Somatic Interrelations," to be presented in the Section on Nervous and Mental Diseases, June 12, will be discussed by *Dr. Lloyd H. Ziegler*, Wauwatosa.

Dr. Stephan Epstein, Marshfield, will present a paper in the Section on Dermatology and Syphilology, June 12, on "Staphylococcic Impetigo Contagiosa."

Dr. James C. Sargent, Milwaukee, will present a paper on "Injury of the Kidneys with Special Reference to Early and Accurate Diagnosis Through Pyelography," in the Section on Urology, June 13.

Dr. Eben J. Carey, Milwaukee, is a member of an advisory group to an exhibit committee which will present in the Scientific Exhibit section of the meeting a special exhibit on lame backs.

Dr. Walter M. Kearns, Milwaukee, will present an exhibit on the causes and treatment of testicular deficiency.

Dr. Arnold S. Jackson, Madison, will present an exhibit on "Goiter and Other Diseases of the Thyroid Gland."

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Among physicians chosen recently or renamed as city health officers are: *Dr. C. D. Boyd*, Kaukauna; *Dr. F. O. Brunckhorst*, Neenah; *Dr. John M. Dodd, Jr.*, Ashland; and *Dr. A. W. Hammond*, Beaver Dam.

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Dr. C. E. Baumle, Monroe, was elected examiner for blind pension applicants in Green county, May 8, by members of the Green county board.

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Dr. E. L. Sevringhaus, Madison, was one of eleven physicians admitted to membership in the Association of American Physicians, May 8. Membership in the organization is limited to 225.

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Members of hospital staffs throughout Wisconsin assisted on May 12, National Hospital Day, with programs of entertainment, demonstrations and tours of inspection, to acquaint the people of their communities with the work and aims of their hospitals.

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Dr. H. O. Schneider, Monroe, has accepted a fellowship in the Cleveland Clinic, Cleveland, Ohio. The fellowship began May 1.

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Minocqua's new lake front park has been officially named Torpy Park, in honor of *Dr. Thomas G. Torpy*, 1895 graduate of Rush Medical College, long in practice in Minocqua.

Pictured above is Dr. John P. Koehler, who will leave the office of health commissioner of Milwaukee on July 1, after fifteen years of service.

Dr. Koehler, who was born in 1880 in Norka, Russia, graduated from the University of Nebraska in 1902; completed a postgraduate course at the Chicago Theological Seminary in 1904; studied medicine while serving as athletic coach at various universities and received his degree in medicine at Marquette University in 1911. He then engaged in private practice until 1918 when he became deputy commissioner of health of Milwaukee. He was appointed commissioner of health in 1925.

Working with the medical profession and health agencies, the Milwaukee health department, during Dr. Koehler's term of office, established a notable health record. In the National Inter-Chamber Health Conservation Contest, conducted since 1929, Milwaukee's health record won first place in 1929, 1931, 1936 and 1939 and second place in 1930, 1932 and 1933. It was excluded from competition in 1934, 1935, 1937 and 1938 to give other cities an opportunity to win.

Dr. Joseph Pessin, Madison, spoke on schizophrenia at a regional meeting of the Wisconsin State League of Nursing Education, held recently at St. Francis Hospital, La Crosse.

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Included among physician speakers at the 31st annual convention of the Wisconsin Congress of Parents and Teachers, held in Fond du Lac, April

23, were *Drs. Amy L. Hunter and H. Kent Tenney*, Madison, and *Dr. E. C. Hartman*, Janesville.

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Dr. E. P. Jordan, assistant editor of the Journal of the American Medical Association, Chicago, addressed over 800 school children, and their parents and teachers at a Junior Red Cross council meeting in Menasha, April 29. His subject was problems in child health. He also addressed a joint meeting of the Neenah and Menasha Lions Club on "A Father Looks at His Child."

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"The Psychologic Aspects of Hitlerism" was the subject of a lecture given by *Dr. W. F. Lorenz*, director of the Wisconsin Psychiatric Institute, Madison, at a dinner meeting of the Unitarian Laymen's League, Madison, on May 3.

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Advances in dentistry and problems connected with dental relief plans occupied the attention of members of the Wisconsin State Dental Society, meeting in Milwaukee, April 22–25.

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Dr. L. M. Morse, Neillsville, officer of the State Board of Health, addressed the normal school students at the State Teachers' College, Stevens Point on "Cancer," May 22.

Coming Events

Wisconsin State Board of Medical Examiners.—The next regular examination of the Wisconsin State Board of Medical Examiners will be held at the Schroeder Hotel, Milwaukee, June 25–28. Applications for reciprocity will also be considered at this meeting.

Fifth Councilor District to Meet in Manitowoc.—The Manitowoc County Medical Society will be host to the Fifth Councilor District Medical Society in Manitowoc, June 27. Officers of the county society are now at work arranging an all-day program for physicians from Manitowoc, Calumet, Sheboygan, Ozaukee and Washington counties. Physicians from Brown, Kewaunee and Door counties are also invited to attend the event.

Michael Reese Hospital, Chicago, to Offer Graduate Course in Electrocardiography.—The cardiovascular department of Michael Reese Hospital, Chicago, will present, August 19–31, a full-time intensive course in electrocardiography for general practitioners. Both group and individual instruction will be given. An hourly program of the course and further information concerning it may be obtained from: Michael Reese Hospital, Cardiovascular Department, 29th and Ellis Ave., Chicago, Ill.

Dedication of Osler Memorial to be Held at Blockley.—The old autopsy house where Osler worked at Blockley has been restored as the Osler Memorial Building, and was dedicated on the grounds of the Philadelphia General Hospital, at Curie Avenue, near 34th and Pine Streets, Philadelphia, Pa., at 2 p. m. on June 8, 1940.

Original furnishings, including the necropsy table, have been collected. The painting by Dean Cornwell, N. A., of New York, entitled "Osler at old Blockley," later to be hung in the building was on exhibition during the celebration.

There are facilities in the building for the housing and preservation of relics of old Blockley, as well as Osleriana. The Committee would welcome any additions to this collection.

A cordial invitation is extended to those who are interested, and especially those who are planning to attend the American Medical Association Convention in New York City June 10–14.

American Congress of Physical Therapy.—The 19th annual scientific and clinical session of the American Congress of Physical Therapy will be held September 2, 3, 4, 5, and 6, 1940, at the Hotel Statler, Cleveland, Ohio.

Numerous new features will be manifest in the 1940 program. Every phase of physical therapy will be covered in the general program, but special emphasis will be laid on the use of physical measures in general practice. Symposia dealing with light, heat and electricity as important therapeutic adjuvants in general medical and surgical practice will be featured.

For information concerning the seminar and preliminary program of the convention proper, address American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

Pan-American Congress of Ophthalmology.—Plans for a Pan-American Congress of Ophthalmology to be held at the Hotel Cleveland, Cleveland, Ohio, October 11–12, have been announced.

The congress will be sponsored by the American Academy of Ophthalmology and Otolaryngology, an organization of more than 2,500 specialists in diseases of the eye, ear, nose and throat, which will hold its annual convention immediately preceding the Pan-American gathering.

The United States Department of State has expressed its interest and the governments of all the countries of the Western Hemisphere have been invited to send official delegates. It is felt that the meeting will do much toward bringing about an *entente cordiale* among scientific men of the two Americas, and it is expected that a permanent organization will be effected.

The committee developing the congress has the following members: Drs. Harry Gradle, Chicago; Conrad Berens, New York; and Moacyr E. Alvaro, Sao Paulo, Brazil. The executive secretary of the American Academy of Ophthalmology and Otolaryngology, which will be host to the Latin-American eye specialists, is Dr. William P. Wherry, 1500 Medical Arts Building, Omaha, Neb.

Under the direction of Dr. Berens, papers in Spanish or Portuguese will be made understandable

to English speaking ophthalmologists by the use of lantern slides projecting a synopsis of each paragraph translated into English. The reverse process will be used with the English papers. Spanish and Portuguese stenographers will be present to record the discussions in the language of the authors.

The congress is open to any ophthalmologist who wishes to register. Nonmembers of the Academy of Ophthalmology and Otolaryngology may register regardless of attendance at the Academy meeting proper. Individual invitations have been sent to about 1,800 members of the ophthalmologic profession in the Latin–American countries, as well as to the national societies of eye specialists and the universities. Individual invitations were not sent to ophthalmologists in the United States and Canada, but official invitations to them are being printed in the various journals of ophthalmology. A fee of $5 has been set for membership in the congress.

Among the guests expected for the congress is Dr. Manuel Marquez y Rodriguez, for many years a prominent eye specialist, teacher and writer in Madrid and now living in Mexico City.

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Abbott Laboratories Offering Fellowships in Chemistry

For the academic year 1940–1941, Abbott Laboratories has established fellowships in several universities with important departments of organic chemistry and biochemistry. The fellowships, carrying stipends of $650 per year, will be available to graduate students in the last or next to last years of graduate work leading to the doctorate degree. The recipients, who are to be selected by the universities in which their work is being done, are not limited as to the subjects on which they will work.

The object of the fellowships is to provide means for the carrying on of additional scientific work in American universities. The future progress of chemical developments in this country will depend upon the availability of well-trained and qualified men, and it is the intent of Abbott Laboratories in establishing these fellowships to lend encouragement in these general fields.

Grants will be made to the following universities:

In organic chemistry: Cornell, Harvard, Illinois and Michigan.

In biochemistry: California, Columbia and Cornell.

BIRTHS

A daughter to Dr. and Mrs. C. F. Broderick, Milwaukee, March 27.

A daughter to Dr. and Mrs. R. G. Piaskoski, Milwaukee, April 7.

A son to Dr. and Mrs. S. C. Weisfeldt, Milwaukee, April 25.

A daughter to Dr. and Mrs. A. G. Schutte, Milwaukee.

A son to Dr. and Mrs. Paul E. Pifer, Kenosha, April 21.

A daughter, Mary Frances, to Dr. and Mrs. George W. Bartels, Janesville, April 16.

DEATHS

Dr. C. H. Erdman, Stanley, died suddenly on April 25 from the effects of a heart attack suffered while he was en route to his home from his office.

Dr. Erdman was born in 1872 near Augusta, Wisconsin. He was graduated in 1893 from the University of Tennessee College of Medicine, and thereafter took up the practice of his profession in Stanley. He remained in practice there until his death.

Dr. Abraham L. Farnsworth, Baraboo, died on April 20 at his home of a heart attack. He had been in ill health for about two years.

Dr. Farnsworth, who was 73 years of age, had practiced in Baraboo for forty years. He was a graduate of the Milwaukee Medical College, class of 1900. He is credited with managing 2,310 successful deliveries and performing or assisting with 1,500 surgical operations in his community.

Dr. Farnsworth was a member and former officer of the Sauk County Medical Society. He was a member of the State Medical Society of Wisconsin and a Fellow of the American Medical Association. He is survived by his widow, three daughters and two sons.

Dr. Ernest A. Guyton, Eau Claire, died on May 13. He was not in active practice, ill health having forced his retirement in 1936.

Dr. Guyton was born in Liverpool, England, in 1864. He received his medical education at Saginaw Valley Medical College, Saginaw, Michigan, being graduated from that school in 1900. He practiced in La Crosse for seven years and then moved to Eau Claire where he remained in practice for twenty-eight years.

Dr. Guyton is survived by his widow and one son.

Dr. William A. Henke, La Crosse, died suddenly on May 8 in the Grandview Hospital of which he was medical director. Death was caused by a heart attack.

Because of waning health, the doctor was planning a vacation in Alaska. He had also announced plans for a merger of the Grandview Hospital with St. Francis Hospital, La Crosse, to relieve him of his hospital duties and place the operation of both institutions in the hands of the Order of Franciscan Sisters. He was to have signed papers effecting the merger on the day he died.

Dr. Henke was 59 years of age. He was graduated from the Illinois Medical College, Chicago, in 1906 and was the recipient of a further medical degree from the University of Illinois College of Medicine in 1913. He spent considerable time in postgraduate study abroad, chiefly in Vienna, Edinburgh and Berne. He practiced for two years in Tomah, going from there to La Crosse in 1911. He maintained weekly office hours in Chicago in addition to his medical work in La Crosse.

Dr. Henke was very active in the La Crosse County Medical Society, being host at dinner meetings of the society on frequent occasions, the last time on May 7. He was chairman of the La Crosse county board of health, which position he held for more than twenty years. He was a past president of the Wisconsin Hospital Association, a member of the State Medical Society of Wisconsin and a Fellow of the American Medical Association.

Dr. Henke is survived by his widow.

Dr. Clarence N. Sonnenburg, Sheboygan, died on May 5 from a heart attack, suffered after he had aided in transporting three victims of an automobile accident to a hospital. He was 48 years of age.

Dr. Sonnenburg was born in Sheboygan in 1892. He was graduated from Marquette University School of Medicine in 1915. According to the *Sheboygan Press*, in the succeeding year, as an interne in an Indianapolis hospital, he attracted national publicity when, with a pocket knife as his only instrument, he performed an emergency cesarean operation on a dead mother, delivering a girl who is alive today.

He spent two years in service during the World War, being stationed at hospitals in Washington, D. C., and Fort Worth, Texas. He was elected coroner of Sheboygan county in 1926 and served in that office for four consecutive terms.

Dr. Sonnenburg was a member of the Sheboygan County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow, three daughters and a son.

Dr. John S. Taugher, Milwaukee, was killed in an automobile accident near Waukesha, May 18. He was 34 years of age.

The young doctor was a graduate of Marquette University Medical School, class of 1933. He served as resident physician at the Milwaukee County General Hospital, Dispensary–Emergency Unit, for several years. About a year ago he purchased the practice of the late Dr. H. S. Kenney of Waukesha, and he was en route to his Waukesha office when the fatal accident occurred. He also maintained an office in Milwaukee. He specialized in the treatment of diseases of the eye, ear and nose.

Dr. Taugher was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association. He is survived by a sister.

Dr. A. R. Wilson, retired Milwaukee physician, died at his home, May 8, after an illness of several years. He was 83 years of age.

He was graduated from the University of Illinois College of Medicine in 1886. He opened his Milwaukee office in 1889, after practicing for three years in Bessemer, Michigan. He had been in active practice in Milwaukee for forty-one years when he retired.

Dr. Wilson is survived by his widow, with whom he celebrated his fiftieth wedding anniversary in 1933.

Dr. J. C. Wright, Antigo, died on May 11 following a stroke. He had been in ill health for some time, but was feeling somewhat improved after a trip to Florida. He was 82 years of age and had been a resident of Antigo for thirty-four years.

He was born in Richland county, Wisconsin. He received his medical education at Rush Medical School, graduating with the class of 1881. The youngest member of that class, he was also its last survivor. A year ago, according to the *Antigo Journal*, when he attended an alumni meeting at Rush Medical School, he was the oldest doctor present and the one who had been in practice the longest.

He began the practice of his profession in Excelsior, Wisconsin. In 1906 he moved his family to Antigo, opened an office and remained in practice there until his retirement a few years ago. He was an enthusiastic sportsman, maintaining a lodge where he went annually for deer hunting.

Dr. Wright, who wrote poetry, was much in demand as a reader at public gatherings. "The Old Wiscons" was one of his most popular readings. He usually introduced it with a short talk about the lumberjacks who made the "drives" on the river in the days when pine was still plentiful. "The Lone Pine Tree" was another popular selection.

For a number of years Dr. Wright was Langlade county physician, and from 1912 to 1914 he was city physician and health officer. He served during the World War as a medical examiner for the exemption board.

Dr. Wright was a life member of the Langlade County Medical Society and the State Medical Society of Wisconsin. He was a member of the American Medical Association. He is survived by three sons and four daughters.

SOCIETY RECORDS

New Members

H. H. Wright, 231 West Wisconsin Avenue, Milwaukee.

A. J. Macht, Winnebago State Hospital, Winnebago.

E. T. Rechlitz, Milltown.

Halbert Gulbrandsen, Viroqua.

G. E. Bryant, Pepin.

Changes in Address

K. W. Davis, Union Grove, to 704 Bond Street, Green Bay.

R. H. Biehn, Statesan, to 2042 Underwood Avenue, Wauwatosa (until October 1, 1940).

H. R. Hathaway, Madison, to Department of Anesthesia, University of California, San Francisco.

L. M. Boxer, Merrillan, to 1011 Milwaukee Avenue, South Milwaukee.

Judson Forman, Wonewoc, to Mount Horeb.

H. M. Buckner, Mount Horeb, to Dodgeville.

Aviation Medicine

By ARTHUR W. HANKWITZ, M. D.
Captain, Medical Reserve Corps, United States Army, Flight Surgeon
Milwaukee

A NEW era in medicine has arisen due to the developments in aviation. As late as 1910 very little was known concerning aviation medicine, and most articles were very speculative in nature. However, in 1910 the Germans quietly studied special qualifications required for aviators and drew up minimum standards for their military pilots. Not until 1917 did the French establish special medical service for aviators in Paris. However, under impetus of the first World War many countries (i.e. England, Poland, Spain, Roumania, Japan, Italy, Sweden, Russia, Bulgaria, Yugoslavia, Holland, Hungary, etc.) became seriously interested in the pilot's medical problems. Experimental laboratories soon began solving such problems as "oxygen want at high altitudes," "air sickness," "visual acuity and depth perception," "fatigue," etc. Aviation medicine did not have its real beginning until after the first World War.

Flight Surgeons in the United States

It was soon found that the medical personnel doing examinations for flyers became more and more involved with intricate and specialized examining procedures. Therefore, in 1919 a school for flight surgeons was established at Mitchell Field, Long Island. In 1926 this school, under direct control of the Air Service Medical Research Laboratory, United States army, was moved to Brooks Field, Texas, and in 1931 to Randolph Field, Texas. Here, beside training physicians as flight surgeons, a great deal of research has been carried on along various lines; namely, the effect of altitude on the human organism, reaction time as it relates to potential flying ability, blind flying as it pertains to disorientation experienced by flyers while using instruments only, eye sensitivity in darkness, proper goggle construction, reaction of the cardiovascular system under stress and strains, effects of fatigue and emotion, etc.

At the present time there are three distinct groups of pilots. First of all the military pilot who passes strict military physical requirements every six months; second, the transport or commercial pilot, who often holds a reserve commission in the air corps; and third, the civilian or private pilot. The latter two types are under direct control and supervision of the C.A.A. (Civil Aeronautics Authority, Washington, D. C.) which appoints flight surgeons to handle physical qualifications.

All flight surgeons at the present time are, or have been at some time, connected with the regular army, the National Guard, or the organized reserve, and received their specialized training at a school of aviation medicine while holding an active officer's commission with the army. There are no civilian schools at the present time, although a number of the leading universities throughout the country will add aviation medicine to their curriculum in the near future. At the present time there are about 500 flight surgeons in the United States and its possessions. Many graduates have retired, become inactive, or are deceased; a few of them have been killed in airplane crashes. Others have full time positions in civilian life with commercial transport concerns, continually checking the pilots and improving the flying comforts of passengers. Flight surgeons on flying status with the air corps are given a special financial remuneration for their added risks.

In the United States army and navy, aviation medicine is specifically designated as a medical specialty and flight surgeons as specialists. In this country no persons except properly qualified flight surgeons are permitted to conduct military aviation examinations or serve with flying units. As in any other specialty, aviation medicine is built on a solid foundation of general medical knowledge, and an intense interest in any one specialty of general medicine is not de-

sirable due to the narrow outlook which usually accompanies such an interest.

A course in aviation medicine covers such subjects as ophthalmology and otology, psychology, neuropsychiatry, personality study, physiology, the cardiovascular system, administration, and physical diagnosis. Under ophthalmology the principles of refraction are included and mastered.

The flight surgeon's duties include the diagnosis and treatment of the general run of medical ailments and he should possess special qualifications in the handling of traumatic cases. These duties also involve the selection of candidates for flying training and the care of the flyer, especially as it pertains to stresses and deleterious environmental influences; he should also act as the pilot's confidant and adviser. Another important duty is to carefully or critically inquire and examine in seeking facts or principles concerning the effect of flight and to find remedies for these environmental conditions which may have an adverse influence.

The following conditions are a few of many which disqualify for flying: epilepsy, asthma, hay fever, syphilis, diabetes, pernicious anemia, leukemia, tuberculosis, rheumatic fever, malaria and endocrine disturbances.

In the neuropsychiatric examination the following traits have been shown by experience to be favorable in the selection of pilots: youth; single status; good family history (i.e. no tuberculosis, nervous or mental diseases, etc.); college education with good scholarship throughout; unusual ability in athletics; few and only minor diseases; no operations, serious injuries or serious stresses; manual dexterity; ability in billiards, tennis, sailing, golf, violin or piano playing, and horseback riding; an active and successful civil life; a liking for normal amusements (no evidences of excesses and dissipations); extreme moderation in use or complete abstinence from tobacco and alcohol; good appetite and digestion; normal sleep and absence of dreams (normal sexual tendencies); good, active, sympathetic cooperation of family in all that pertains to flying; and normal reactions throughout physical examination. In temperament, the ideal pilot is cheerful, stable, self-reliant, aggressive, modest, frank, fond of people, satisfied, punctilious, serious, cooperative, a "good sport," enthusiastic, adaptable, and of moderate tension. His intelligence should be precise, penetrating, sharp, alert and resourceful. In volition he should be energetic, quick, deliberate or moderately impulsive, controlled and with good tenacity of purpose. Psychic conditions which disqualify for flying include chronic alcoholism or drug addiction, stuttering or stammering, migraine or frequent headaches, fainting or dizzy spells without reasonable explanation, nervous instability, history of having been committed to an institution, somnambulism, pavor nocturnus, amnesia, insomnia or history thereof, obsessions or phobias.

It is said by old army flyers that every pilot, irrespective of experience, has been air sick at some time or another in his career. Lack of fresh air, excessive heat, rough air currents, altitude, blind flying, fatigue and worry all tend to increase the possibility of the development of air sickness in a pilot or passenger. There is no specific remedy for the treatment of this condition. The correction of any of the above mentioned causative factors is the best therapy. Commercial pilots are restricted to a 300 foot change of altitude per minute to help prevent air sickness of passengers.

Physical Problems in Aviation

Since all flying activity takes place above sea level, the problem of oxygen deficiency is of very vital concern. The percentage of oxygen in normal atmospheric air is a little less than 21 per cent, irrespective of altitude. However, the higher one flies, the lower the barometric pressure becomes, and, consequently, the lower the partial pressure of oxygen becomes. Thus, oxygen-want is experienced at 10,000 feet or sooner, depending on the general condition of the human organism. Respirations are increased, circulation whipped up, blood pressure rises, oxygen-carrying red cells are stimulated to increase,—all in a compensatory attempt to overcome the lack of oxygen. Marked asphyxia develops rapidly above

12,000 feet. As altitude is increased sleepiness, headache, altered respiration, lassitude, fatigue, psychologic impairment and euphoria develop, which is anything but a painful or disagreeable process. Due to this abnormal sense of well-being, with impaired judgment, accidents may occur. If altitude is gained too rapidly, especially above 30,000 feet, aeroembolism occurs, a condition analogous to divers' paralysis (caisson disease, commonly known as the "bends") which occurs when a deep sea diver rises to the surface too rapidly. This "decompressed air illness" is characterized by small joint pains, itching, urticaria, nerve pain, paralysis, convulsions and even coma. Some cough and chest pain with a burning or stabbing sensation may also be experienced. This condition may also lead to crashes. To prevent aeroembolism from developing in pursuit pilots who have to climb to 30,000 foot altitudes rapidly, a midwestern clinic has suggested that the men breathe pure oxygen for one hour or walk on a treadmill at four to six miles an hour, for a period of one-half hour previous to their flight, to eliminate the nitrogen from their body tissues. From what I know of fighting pursuit pilots, I am afraid a more practical solution will have to be worked out since time plays a major role in aircraft tactical problems.

Military fliers are compelled by regulations to use oxygen at 10,000 feet if they remain at this altitude for six hours or longer, and are compelled to utilize oxygen at all times while flying above 15,000 feet. In the past it has been found that when pilots fly considerably, over a period of months, at altitudes of between 12,000 and 18,000 feet, a chronic altitude sickness develops, consisting of a deterioration characterized by increasing irritability, nervousness, insomnia, difficulty in mental concentration and attention, and disregard for danger in the air. It was found, too, that their ceilings became progressively lower and they became chronically fatigued and stale.

To eliminate uncomfortable oxygen masks and equipment for individual passengers in commercial aviation, a satisfactory type of pressure cabin has been fairly well perfected. These sealed, high altitude aircraft will probably cruise at 30,000 feet or higher, and thus speed will be considerably increased on transcontinental and intercontinental air lines in the near future. A January, 1940, report announced the purchase by a large American commercial aircraft concern of fourteen four-engine 4,500 horse power, forty-passenger planes, with a cruising range of 2,000 miles and cabins constructed to provide low level atmosphere when the ships cruise at high altitudes. Temperature, humidity, ventilation, carbon monoxide, carbon dioxide and oxygen requirements are some of the problems which must be accurately controlled in the above-mentioned planes. Proper insulation against noise and vibration are very important.

Since the greatest speed made by man approaches 600 miles an hour, while power diving in a pursuit ship and the fastest level flight nears 500 miles an hour, it can readily be seen new problems are facing the flight surgeon daily. At the present time it is generally assumed by army medical personnel that the limit of human endurance will keep controllable speeds at about 500 miles an hour. Beside speed, acceleration is a serious problem with the flight surgeon. During a quick change of direction in flight, serious damage may be done to the occupants. It is not uncommon to find many older active army pilots with hernia scars and a history of multiple surgical repairs. This breakdown of lower abdominal wall structure is assumed to result from fast power dives when the pilot pulls his ship out of the dive and a terrific stress results on the lower abdominal structures which support the contained abdominal organs. Too, the blood following a purely hydrostatic principle, will cause a temporary anemia of the brain which may be severe enough to cause unconsciousness followed by a complete washout. In military air craft, personnel will be found in all positions in the same plane, i.e., bomber lying in a prone position, machine gunner sitting sideways, etc., and speed and acceleration are some of the forces acting on the semi-circular canals, cardiovascular system and other vital structures, so as to cause distress and inefficiency.

Pertaining to airplane crashes, I was once given the startling information by an old army pilot of field grade, that at the present time, with the modern equipment available and strict regulations concerning flying, it is practically always somebody's fault when a crash occurs. He recalled many accidents and explained that in most cases poor judgment was shown by the pilot, or a worn motor was not properly repaired or replaced by the ground crew, or someone had carelessly failed to remove a control block, etc. Because of this fact, the air corps, United States army, has endeavored to surround itself with personnel of exceptionally high caliber and capabilities.

Airplane Ambulance Service

Another important phase of aviation medicine includes the transportation by air of the sick and wounded. During peace time, many passengers with organic heart disease and other organic deficiencies, travel daily in our large commercial transports. The dangers of anoxemia to passengers with cardiac and respiratory difficulty may begin soon after they have left the ground, but there is no danger if oxygen is properly administered. It is now generally agreed that if a person with heart disease is able to walk, he is able to fly, in so far as safety and comfort is concerned, provided oxygen is used if and when it is needed, irrespective of the altitude of flying.

During war time, the airplane ambulance is now a satisfactorily proven means of evacuation. In the late German–Polish campaign, more than 2,500 sick and wounded were carried by air. Since air transportation is quicker and gentler than that afforded by the auto ambulance, seriously wounded individuals can now be transported by air, providing an experienced medical attendant is present to use oxygen when indicated. However, the flight surgeon must prohibit persons from going into the air who are suffering from shock, pneumonia, severe hemorrhage and anemia, and those recently operated on. Moreover, blood banks at the front and the giving of emergency transfusions when indicated may properly prepare the wounded for air evacuation. According to the chief of the German medical air service, only in important cases, such as in cerebral gunshot injury, facial gunshot wound, eye injury, spinal and pelvic injury, and injury of the extremities requiring long continued orthopedic treatment, is expensive air transportation required.

Reregistration Under the Harrison Narcotic Act and the Marihuana Tax Act of 1937

The attention of Wisconsin physicians is called to the fact that applications for reregistration under the Harrison Narcotic Law must be filed on or before July 1 and the special tax of $1 paid at that time. The application must be accompanied by an inventory, prepared in duplicate and under oath, of narcotics on hand as of December 31 preceding the date of application or any date between December 31 and the date of application.

Severe penalties are provided for physicians and others who violate or fail to comply with any provision of the sections relating to registration and payment of tax for dispensing narcotics. These include a fine up to $2,000, or imprisonment up to five years, or both; and, in addition, a fine up to $10,000, or imprisonment up to one year, or both, together with costs of prosecution; and, in addition, a fine up to $10,000, or imprisonment up to five years, or both, together with costs of prosecution. The law also provides additional severe penalties beyond those above enumerated.

Penalties up to $2,000 or imprisonment up to five years, or both, are also provided for registrants under the Marihuana Tax Act of 1937 who fail to reregister on or before July 1.

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New Panel Listing to Be Prepared for Compensation Insurance Carriers

EACH member of the State Medical Society of Wisconsin has received an application blank for listing or relisting on the workmen's compensation insurance panel prepared annually by this Society, and forwarded to insurance carriers selling compensation insurance in Wisconsin.

The conference committee established under the agreement providing open panels in Wisconsin, to which the State Medical Society, the American Mutual Alliance and the Association of Casualty and Surety Executives are parties, directed that a new panel be prepared in accordance with the agreement.

Any member of the State Medical Society, in good standing, is eligible to apply for listing on the panel which is supplied to insurance carriers in the State. The insurance companies coming under the agreement write upward of 90 per cent of the compensation insurance policies written in Wisconsin.

In making application for listing on the workmen's compensation panel, each member of the Society subscribes to the spirit and the letter of the agreement which has been reached between the Society and the insurance carriers, and further agrees to certain simple, common sense provisions. Specifically, each member agrees to the following:

"1. I am to provide such reports to the insurance companies as may be reasonably necessary.

"2. I am to submit disputes to the Conference Committee, established by the Society and the insurance companies, to the end that they may be, if possible, settled amicably and to the best possible advantage of the patient and other interested parties.

"3. When consultation is desirable, I shall obtain consent of the insurance company, when possible, prior to calling in consultation, and whether consultation is requested by me, the patient, or the insurance company, every effort will be made to secure a consultant mutually acceptable."

Question has arisen on previous occasions as to the reasons why several recognized specialties have not had separate listing on the panels prepared for the insurance carriers. This question has been repeatedly discussed by the Conference Committee on Open Panels established under the agreement. The reason these special listings have not appeared on the panels to date is that the injured employee or his fellow workmen are not competent to judge if the services of a specialist are indicated or to select the specialist to whom the injured employee should be referred, except in the specialty of eye, ear, nose and throat practice, in which it is felt that accurate referral is possible. When specialty care is required, it is assumed that the physician in charge will call the proper specialist in consultation. This question was referred by the conference committee to the Council of the State Medical Society of Wisconsin for advice and this ruling of the conference committee was concurred in by the Council.

Members of the Society who limit their practice to specialties other than eye, ear, nose and throat practice are, by rule of the Conference Committee on Open Panels, not listed as general practitioners, as the agreement provides that the physician whose name appears on the panel stands ready to accept and render treatment in all compensation cases.

Each member of the Society is urged to forward at once the application for listing on the panel, mailed from the State Society offices on May 28, that his name may be included in the list which is sent to the insurance companies.

All applications for listing or relisting on the panel must be received on or before June 15, when preparation of the panel for mailing to the insurance companies will begin.

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The Registry for Clinical Laboratory Technicians

The Journal has been requested by Dr. Philip Hillkowitz, chairman, Board of Registry of Medical Technologists of the American Society of Clinical Pathologists, 234 Metropolitan Building, Denver, Colorado, to call attention to the following editorial in the Journal of the American Medical Association for March 30, 1940, pp. 1269–1270.

In 1928 the American Society of Clinical Pathologists established a Registry to pass on the qualifications of laboratory technicians and to approve schools for training these workers. Soon this Registry received the recognition of the American Medical Association, the American College of Surgeons, the American Hospital Association, the Catholic Hospital Association and other scientific and medical organizations. The Council on Medical Education and Hospitals was authorized to formulate standards and approve schools which meet its requirements. After a thorough test, conducted by clinical pathologists, successful applicants for a certificate were designated as Medical Technologist (M.T.), a title which connoted a holder of a certificate of competence from the Registry, nationally recognized in the medical and hospital spheres. Within the past six months one C. A. Bartholomew of Red Bank, N. J., who has never himself been registered, began to circularize the medical laboratory technicians of New England asking them for a fee of $5 to join the "American Medical Technologists" and offering to bestow the title M.T. by virtue of a charter from the state of New Jersey. As far as we know, this movement is not supported or authorized by any scientific body. The promoters seem, moreover, to have undertaken the task of passing on the competence of training schools for medical technologists. In this they seem to be abetted by the proprietors of some commercial schools which have not themselves been approved by the Council on Medical Education and Hospitals and the Registry. This would seem to be the old technic of having one soiled hand wash the other. Graduates from these unapproved schools who are ineligible for the Registry's examination seem to be welcomed into the "American Medical Technologists." Indeed, a teacher of one of these schools has, it is reported, solicited its graduates to join this organization at reduced rates. Complaints have come to both the Council and the Registry against the efforts of this unauthorized and irresponsible body to undermine the scientific and ethical standards that have been set up for the practice of this important vocation by the American Medical Association and the American Society of Clinical Pathologists. Certainly physicians everywhere will do their utmost to inform young men and women who contemplate a career in medical technology of the hazard that lies in participation in such courses or organizations.

The Journal Bookshelf

Diabetes: Practical Suggestions for Doctor and Patient. By Edward L. Bortz, A.B., M.D., F.A.C.P., associate professor of medicine, Graduate School of Medicine, University of Pennsylvania; chief of medical service B, The Lankenau Hospital, Philadelphia; assistant editor, *The Cyclopedia of Medicine.* With a foreword by George Morris Piersol, B.S., M.D., F.A.C.P., professor of medicine, Graduate School of Medicine, University of Pennsylvania; editor in chief, *The Cyclopedia of Medicine.* Ed. 2. Cloth. Price, $2.50. Pp. 296, illustrated. Philadelphia: F. A. Davis Company, 1940.

Arthritis and Allied Conditions. By Bernard I. Comroe, A.B., M.D., F.A.C.P., instructor in medicine, University of Pennsylvania; ward physician, Hospital of the University of Pennsylvania. Cloth. Price, $8.50. Pp. 752, illustrated with 200 engravings. Philadelphia: Lea & Febiger, 1940.

Synopsis of Obstetrics. By Jennings C. Litzenberg, M.D., F.A.C.S., professor emeritus of obstetrics and gynecology, University of Minnesota Medical School, Minneapolis. Cloth. Price, $4.50. Pp. 394, with 157 illustrations including 5 in color. St. Louis: The C. V. Mosby Company, 1940.

Biochemistry of Disease. By Meyer Bodansky, Ph.D., M.D., director of the John Sealy Memorial Laboratory and professor of pathological chemistry, University of Texas School of Medicine. In collaboration with Oscar Bodansky, Ph.D., M.D., lecturer in biochemistry, Graduate Division, Brooklyn College; formerly, biochemist, Children's Medical Division, Bellevue Hospital and instructor in the department of pediatrics, New York University College of Medicine. Cloth. Price, $8. Pp. 684, illustrated. New York: The MacMillan Company, 1940.

Obesity and Leanness. By Hugo R. Rony, M.D. formerly attending physician, Cook County Hospital; formerly associate in medicine and chief of endocrine clinic, Northwestern University School of Medicine, Chicago. Cloth. Price, $3.75 net. Pp. 300 illustrated with 32 engravings. Philadelphia: Lea & Febiger, 1940.

Anatomical Analysis of Sports. By Gertrude Hawley, M.A., formerly in charge of physical education for women at Northwestern University and Stanford University. Cloth. Price, $3. Pp. 191 illustrated. New York: A. S. Barnes and Company 1940.

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Part II, in which the diseases of the gallbladder itself are discussed, includes a consideration of diagnosis and an extensive discussion on the different types of cholecystic disease. The chapter on noncalculous cholecystitis is extremely interesting and the causes for poor results are well treated.

In Part III the diseases of the bile ducts have been handled in an admirable manner and much useful information can be obtained from this chapter.

In Part IV medical and surgical treatment is taken up in detail and the causes of failure and the difficulties encountered are well presented.

In Part V preoperative and postoperative care have been given a great deal of consideration and of particular interest to the reviewer was the chapter on diets, the vitamin concentrates and the methods used to combat certain symptoms and complications. The chapter on symptoms following that on cholecystectomy and other operations on the gallbladder answers many questions which heretofore have been grossly exaggerated as well as misunderstood, and gives a clear insight as to the causes of these failures. At the same time this chapter makes it quite clear that patients are sometimes little benefited by operation. The necessity for careful differential diagnosis has been pointed out and a detailed discussion given of the later ideas regarding biliary dyskinesia.

This volume is extremely well fortified with an extensive bibliography. The authors and eight contributors have succeeded in presenting a most excellent book dealing with diseases of the biliary tract. It can be recommended without reservation for extensive use of the student as well as all those surgeons who are interested in diseases of the biliary tract. J. W. G.

Ten Years in the Congo. By W. E. Davis. Cloth. Price, $2.50. Pp. 301. New York: Reynal & Hitchcock, 1940.

No single book based on Africa can adequately picture more than a tiny part of that immense continent. This account of the experiences of a missionary doctor claims no more than that but the picture he draws gives the reader a fascinating view of that particular part of the Belgian Congo in which he worked. The writer does not spoil his effort by heavy sermonizing but he writes as though he were talking to you of his adventures and anticipating your questions before you ask them.

A number of case histories are given which make the life of the American practitioner seem almost drab. Surgery is practiced among the African natives with the minimum of equipment and supplies but the amazing ability of these people to survive when a white person wouldn't have a chance in a thousand is illustrated again and again.

Chapters are devoted to birth, marriage, death, witch doctors and other Congo customs as well as to the European planters, traders and administrators who live there from far different motives than the author of this book did. No story of Central Africa would be complete without mention of the animal kingdom and no one can remain there long without feeling that God created that land for the ants—and they have no intention of giving it up. Dr. Davis came away with a great deal of respect for them and tells you why. He also brought back that strange desire to go back that afflicts so many who have once lived there. Some who read this book will understand. L. L.

Handbook of Skin Diseases. By Leon H. Warren, B.A., M.D., M.Sc. (Med.), formerly instructor in dermatology and syphilology at the School of Medicine, Temple University; acting assistant surgeon (dermatology) in the office of Dermatoses Investigation of the United States Public Health Service; assistant dermatologist, Philadelphia Methodist Hospital. With a foreword by Frederick D. Weidman, M.D. Cloth. Price, $3.50. Pp. 321. New York: Paul B. Hoeber, Inc., 1940.

This is a pocket-sized volume of over 300 pages which is intended to be a time saver and handy memory refresher for the student and practitioner of medicine. It is based on the proposition that the medical curriculum of today is so crowded that medical students are inadequately trained in dermatology and graduates possessed of only a minimal smattering of knowledge about the abnormalities of the skin.

The author has attempted to overcome this deficiency in dermatologic teaching by this work. It is a synopsis of the salient features of some 250 of the more commonly encountered skin diseases. A

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derivation of the name of each disease is given together with the synonyms and eponyms. Then follows a meaty discussion of the essential features of each with emphasis on the diagnosis and treatment. All this is in telegraphic style to save further on time and space.

The first portion of the volume is concerned with the general principles of therapy. There are concise, well-written paragraphs on nonspecific methods of hyposensitization, endothermy and various kinds of compresses, powders, ointments, lotions, pastes and emulsions.

To quote Dr. Weidman "The book merits success." R. L. McI.

Cancer in Childhood and a Discussion of Certain Benign Tumors. Edited by Harold W. Dargeon, M.D., F.A.A.P., attending pediatrician, Memorial Hospital for Cancer and Allied Diseases, New York; associate pediatrician, St. Luke's Hospital, New York; associate pediatrician, New York Foundling Hospital; instructor in pediatrics, College of Physicians and Surgeons, Columbia University. Cloth. Price, $3. Pp. 114, illustrated. St. Louis: The C. V. Mosby Company, 1940.

This small volume consists of a series of papers which comprise a timely symposium on cancer and benign tumors of infancy and childhood. The incidence of malignant tumors, their peculiarities of growth in the young subject as compared to growth in the adult, and their anatomic distribution are thoroughly discussed. New growths involving the various organs and systems of the body are considered by specialists in the various fields.

The purpose of this book is to make the practitioner conscious of the possibility of malignant disease in young individuals. It also stresses the need for early diagnosis and treatment since most of the tumors of early life are composed of rapidly growing young cells and are quickly fatal. Because of their embryonic character many of these tumors are particularly responsive to therapy with x-ray and radium.

Anyone who is concerned with the welfare of infants and children should be familiar with the contents of this volume. K. B. McD.

Essentials of the Diagnostic Examination. By John B. Youmans, B.A., M.S., M.D., associate professor of medicine and director of postgraduate instruction, Vanderbilt University Medical School. Cloth. Price, $3. Pp. 417, illustrated. New York: The Commonwealth Fund, 1940.

This small compact book is divided into two main portions. The first deals with the history and physical examination, and the second with laboratory tests. It contains a remarkable amount of information for its size. This is accomplished chiefly through good organization of material and the inclusion of a number of charts. However, the reviewer would question the advisability of attempting to condense so much material into one small volume, at the expense of completeness. So many good books on each phase herein treated are already available that the reviewer questions if there is any particular need for a rather dogmatic presentation of this type, such as is unavoidable in so condensed a book.

Obviously then, this small volume is in no sense a textbook, but may prove to be a useful guide, especially to the general practitioner who attempts to carry out his own laboratory work. M. L. C.

A Textbook of Physiology. By William D. Zoethout, Ph.D., professor of physiology in the Chicago College of Dental Surgery (Loyola University), and W. W. Tuttle, Ph.D., professor of physiology, College of Medicine, State University of Iowa. Ed. 7. Cloth. Price, $4.50. Pp. 743, with 302 illustrations. St. Louis: The C. V. Mosby Company, 1940.

The new seventh edition of this widely used textbook of physiology adds W. W. Tuttle as co-author. Its continued use over a period of almost twenty-five years speaks for the success with which it fills in the gap between standard medical works and elementary texts. The authors handle the difficult task of presenting recent progress along many fronts without disturbing the balance and unity which have always characterized the text. The presentation is occasionally didactic, giving an unwarranted sense of completion to fields still in a state of flux. The reference to old reviews, advanced texts and monographs might be profitably supplemented or replaced by a wider use of recent original source material, thus introducing the student in a more direct way to those engaged in the evolution of this rapidly changing science. The book is well illustrated and printed on a tinted paper which makes it easy to read. F. A. H.

Management of Obstetric Difficulties. By Paul Titus, M.D., obstetrician and gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; consulting obstetrician and gynecologist to the Pittsburgh City Homes and Hospital, Mayview, and to The Homestead Hospital, Homestead, Pa.; secretary of The American Board of Obstetrics and Gynecology. Ed. 2. Cloth. Price, $10. Pp. 968 with 368 illustrations and 5 color plates. St. Louis: The C. V. Mosby Company, 1940.

This text is very well organized as to subject matter, very logically written, and should be of real interest to those interested in obstetric complications. It can be recommended as a text with no degree of hesitation. R. E. C.

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RYERSON—LOW BACK PAIN

(Continued from page 461)

Metastatic carcinoma, especially of prostatic origin, must always be borne in mind, and can usually be demonstrated on roentgen examination. New growths limited to the sacrum may be encountered, and are usually myxomatous. Ghormley's "facet syndrome" may be due to arthritis in the lumbar articulations, or to the flattening of an intervertebral disc which allows the upper vertebra to sink down upon the lower, and thus narrows the lateral foramens through which the lumbar nerves pass.

The ligamentum flavum, a dense fibrous ligament connecting the laminae together, has been described by Spurling as becoming thickened and hypertrophied, and exerting painful pressure on the dura and the cord. I have not personally seen such a case, and I do not know any reason why such hypertrophy should occur. Ober, of Harvard, believes the tensor fascia lata of the thigh becomes contracted and causes back pain. This theory is still in the controversial stage.

Vertebral epiphysitis.—Children and adolescents sometimes develop pain in the lower back because of a peculiar disturbance of the bodies of the vertebrae. The exact cause is not definitely known, but it is undoubtedly allied to the conditions observed in the head of the femur in Legg–Perthes' disease (osteochondritis juvenilis coxae), Köhler's disease of the navicular bone of the foot, Osgood–Schlatters' disease of the tubercle of the tibia, and other similar growth disturbances. The ossification of portions of the vertebral bodies is delayed, and the epiphyseal plates may be penetrated by the intervertebral disc or the nucleus pulposus, through small holes in the plates. The description given by Scheuermann is concerned with the areas of osteochondritis in the vertebral bodies where ossification is incomplete, and with the wedge-shape of the vertebrae. Schmorl's articles deal more with the penetration of the epiphyseal plates by the nucleus pulposus. It is quite probable that these different manifestations are simply different stages of the same disorder. They are frequently seen in combination in individual

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patients, and may be successfully treated by braces, rest, calcium preparations and, where the basal metabolism is low, by thyroid extract.

In conclusion, let me say that cases of low back pain require careful consideration from many different angles. The treatment depends upon the diagnosis, and may consist of manipulation, strapping, fixation by plaster-of-Paris body jackets, or operations such as laminectomy and spinal fusion by the bone grafting method.

CAREY—LOW BACK PAIN

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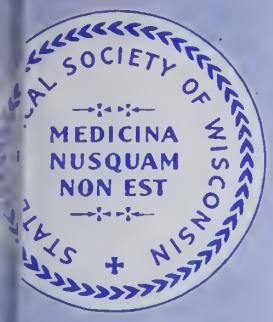

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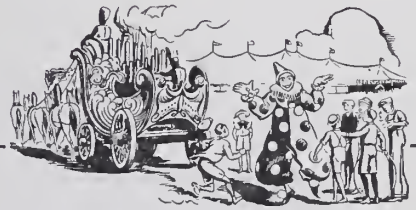

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Man	12–15 mg.
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REFERENCES

(1) 1939. Mineral Metabolism, Alfred T. Shohl, Reinhold, New York, N. Y.

(2) 1939. Food & Life, Yearbook of Agriculture, U. S. Dept. of Agriculture, U. S. Govt. Printing Office, Washington, D. C.

(3) 1940. J. Nutrition 19, 449.

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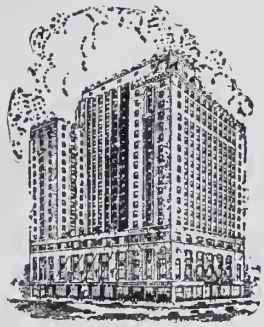

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THE WISCONSIN MEDICAL JOURNAL

VOLUME XXXIX, NO. 7 Copyright, 1940, by The State Medical Society of Wisconsin JULY, 1940

A Clinical Classification of Hemorrhagic Diseases Due to Coagulation Defects*

By ARMAND J. QUICK, M. D.
Milwaukee

DURING the past five years tremendous progress has been made both experimentally and clinically in the understanding and handling of hemorrhagic diseases. This new information makes it possible to present a new classification of the bleeding diseases which are caused by a disturbance of the coagulation mechanism. Such a systematic grouping will serve both as a concise summary of existing knowledge and as a guide to therapy.

Before presenting this new classification it is essential to review briefly the present concept of the coagulation mechanism. Four substances are necessary to bring about the clotting of blood. Three of these, namely, prothrombin, thromboplastin and calcium, interact to form thrombin. The fourth primary agent is fibrinogen, which is converted through the action of thrombin to fibrin, which constitutes the visible phase of the clotting process. Obviously, a lack of any one of the four primary agents can bring about a delay or total inhibition of coagulation. Significantly three of these are present in great excess. There is at least five times more prothrombin in human blood than is needed for a normal coagulation time. Fibrinogen can be reduced from the normal concentration of 0.3 per cent to as low as 0.02 per cent without any evidence of defective coagulation. In regard to calcium, a wide variation in its concentration can occur without influencing the clotting time, and within the range that is compatible with life (which is roughly 5 to 20 mg. per 100 cc. of blood) the clotting time is little altered.

It is an interesting fact that these three clotting agents which are present in amounts far above the minimum required for normal clotting are moreover extracellular and free, i.e., in their reactive form. In marked contrast, active thromboplastin is always limited in quantity and in the intact organism it probably remains completely in the inactive state. It is widely distributed and occurs in nearly all tissues. In the brain and lungs it is especially abundant. Ordinarily, however, the platelet is the main source of the thromboplastin which enters into the coagulation reaction. The clotting time of a sample of blood that is uncontaminated with tissue juice is really a measure of the rate with which thromboplastin is liberated from the platelets. Thus, if 1 cc. of human blood is put into a test tube, it will clot in five to eight minutes, whereas if the same amount of blood is mixed with a drop of a potent preparation of thromboplastin a solid clot will form in fifteen seconds. This simple experiment clearly demonstrates how slowly thromboplastin is released from the platelets even in normal blood. It is not surprising therefore to find a deficiency of free thromboplastin an important cause of hemorrhage.

Thromboplastin Deficiency, Hemophilia

The total amount of thromboplastin in the tissues or even in the blood is of relatively little importance; in fact, it is doubtful whether the thromboplastin content of the body is ever diminished. It is the rate with which thromboplastin is liberated, particularly from the platelets, which is of paramount importance. An increase in the stability of the platelets is one of the most important causes of a prolonged coagulation time, and it is highly probable that this is

* From the Department of Pharmacology, Marquette University School of Medicine. Presented before the 98th anniversary meeting of the State Medical Society of Wisconsin, September, 1938.

the true cause of hemophilia. If thromboplastin is added to hemophilic blood, clotting occurs as promptly as in normal blood. Obviously, hemophilic blood differs from normal blood in that it lacks the clotting factor which is derived from the platelets. The problem of finding the cure for hemophilia requires discovering the means for changing the stability of the platelet. Until such time, treatment will remain empirical and ineffective. Recognition must be given to the fact that hemophilia has spontaneous and sudden remissions. This can easily lead to the error of mistaking such a remission period as a response to a new remedy. Little has been accomplished by the hit and miss therapeutic attempts of the past, and basic research offers the best hope for the solution of this baffling hemorrhagic disease. It was fundamental research balanced with judicious clinical application that achieved such brilliant results in the group of bleeding diseases which will now be discussed.

Prothrombin Deficiency

Although the prothrombin concentration in human blood is approximately five times more than is physiologically required, a deficiency of this agent can occur which may be sufficiently severe to result in fatal hemorrhage. It is now firmly established that the organism is dependent upon an accessory food factor, namely vitamin K, for the synthesis of prothrombin. Recent researches have demonstrated that a series of rather simple chemical compounds containing the naphthoquinone nucleus have strong vitamin K activity and one of these, phthiocol, significantly is a product of the tubercle bacillus. Other bacteria too, many of which inhabit the intestinal tract, produce vitamin K. Thus, this substance is derived both from plants such as alfalfa and young grasses and from bacteria.

Theoretically, a prothrombin deficiency can result in three different ways: (1) insufficient intake of vitamin K, (2) inadequate absorption of this vitamin, and (3) severe liver damage in which condition the vitamin K cannot be efficiently converted into the prothrombin component.

In regard to the first class, it is improbable that an adult can develop a prothrombinopenia due to an inadequate intake of vitamin K since the bacteria of the alimentary canal are constantly producing this substance. In the newborn baby, however, a peculiar situation is encountered. At birth the prothrombin of the blood is nearly normal, but in a very short time it drops sharply, often to a dangerously low level. Presumably the baby is born without any store of vitamin K, and the prothrombin present in the blood is rapidly exhausted and remains low until vitamin K becomes available. Normally a prompt spontaneous rise occurs, but in certain instances a delay in this recovery is encountered, and the hemorrhagic disease of the newborn results. It is to be emphasized that every baby is potentially in danger of this hemorrhagic tendency; therefore, constant vigilance during the first few days of the infant's life is demanded. Fortunately a concentrate of vitamin K given orally is not only highly effective but also prompt in its action. If a baby shows any signs of hemorrhage, however insignificant, or if the delivery was difficult and intracranial injury is suspected, vitamin K should be given immediately. No surgical operations should be undertaken until the baby is a week old, or unless the prothrombin is normal. If the need of an emergency operation arises, vitamin K should be given preoperatively.

The most common cause of decreased prothrombin in the blood is the inadequate absorption of vitamin K. This substance is fat soluble, and, in the absence of bile salts in the intestine, it fails to be absorbed. Obstructive jaundice is the condition in which this occurs most commonly, although in all other states in which bile fails to enter the intestine, a vitamin K deficiency can occur. Furthermore, in any severe pathological condition of the intestinal tract such as sprue and ulcerative colitis, the absorption of vitimin K may be so reduced that a diminution of the plasma prothrombin follows. In all diseases in which an inadequate absorption of vitamin K is suspected, especially in every case of jaundice, a quantitative determination of prothrombin should be done. If the concentration is reduced, vitamin K and bile salts should be given, particularly if the pa-

tient requires an operation. If the prothrombinopenia is due purely to an inadequate absorption of vitamin K, the response to the oral administration of this substance together with bile salts is amazing. It is not unusual to increase the prothrombin from less than 10 per cent to almost normal in twelve hours with relatively small doses of a vitamin K concentrate.

If vitamin K cannot be given orally either because of vomiting or intestinal disease which interferes with absorption, phthiocol, a simple naphthoquinone compound which is water soluble, can be given intravenously.

Unfortunately not all icteric patients respond promptly to vitamin K therapy. In toxic jaundice and even prolonged obstructive jaundice, liver damage is present; consequently the body's ability to synthesize prothrombin from vitamin K may be greatly impaired. The result is that even though adequate amounts of both vitamin K and bile salts are given the prothrombin level is elevated with difficulty. Any patient with a low prothrombin concentration who fails to respond to vitamin K and bile salts is likely to have an impaired liver function. In such cases determination of the liver efficiency as well as a quantitative estimation of prothrombin should be made. For the former, the hippuric acid test is perhaps the most satisfactory. If liver damage is found, attempts should be made to treat the liver. The intravenous injection of glucose is a well recognized means, and in addition the injection of calcium in the form of calcium gluconate, as well as the feeding of gelatin or glycine, can be suggested. To treat a jaundiced patient merely with vitamin K and bile salts is not sufficient. Even though he is saved from hemorrhage, he can still die from acute hepatic insufficiency which in more common parlance is called liver death.

Fibrinogen Deficiency

Since the fibrinogen of the blood may be markedly decreased in severe liver diseases, it was commonly assumed that the bleeding tendency observed in such conditions was due to the low fibrinogen concentration. It is now known that the prothrombin may be even more drastically reduced in toxic hepatitis. While it is true that the fibrinogen is often extremely low in diseases involving the liver, in certain nutritional deficiencies and various other conditions, it is doubtful whether hemorrhage occurs except in rare instances. There are, it seems, only two types of fibrinogenopenia in which a true hemorrhagic diathesis is observed. The first is acquired, and rather surprisingly is found in diseases not involving the liver but the bone marrow. In the cases reported, extensive destruction of the bone marrow had occurred either due to tuberculosis or to carcinomatous metastasis. The second type is congenital absence of fibrinogen in the blood. Only three cases have ever been reported, and these can be considered distinctly medical curiosities. A diagnosis can only be made by a quantitative determination of the fibrinogen of the blood. Treatment is unsatisfactory in both types. Theoretically a transfusion is indicated whenever hemorrhage threatens. It would be interesting to find how long the fibrinogen supplied by the transfusion remains in the body.

Calcium Deficiency

There is no convincing evidence that the calcium concentration of the blood is ever sufficiently altered to bring about a significant retardation of the clotting time. Although calcium is exceedingly important in the coagulation process, no bleeding condition has been found that can be specifically attributed to calcium deficiency. It is doubtful if the administration of calcium salts to prevent or treat excessive bleeding has any valid experimental or clinical basis. It is possible, however, that, in jaundice, calcium may be beneficial,—not because of any direct action on the coagulation process, but indirectly by its therapeutic effect on the liver, thus increasing the organ's efficiency in synthesizing prothrombin.

Antithrombins

Much has been written in the past about the antithrombins of the blood, and nearly all of the bleeding diseases have at one time or another been attributed to these hypothetical substances. Careful research has shown that normal blood does not contain any antithrombin or anticoagulant which in any way interferes with clotting. Experimentally, it

is possible to bring about a marked outpouring of an anticoagulant,—presumably, heparin. This is accomplished either by the injection of peptone or of a protein to which the animal has been sensitized. Usually the effect disappears in one to three hours. It is quite possible that in human anaphylactic shock, the incoagulability of the blood is likewise caused by the liberation of heparin. Since the danger of hemorrhage is insignificant, treatment is unnecessary. No other hemorrhagic disease has been found in which an anticoagulant can be considered the causative agent.

Summary

The following outline summarizes the hemorrhagic diseases due to a disturbance of the coagulation mechanism.

I. Thromboplastin Deficiency.
  A. Abnormal resistance of platelets.
    a. Hemophilia.
      Treatment: No specific remedy known.

II. Prothrombin Deficiency.
  A. Inadequate supply of vitamin K.
    a. Hemorrhagic disease of the newborn.
      Treatment: Oral administration of vitamin K.
  B. Faulty Absorption of vitamin K.
    a. Obstructive jaundice or biliary fistula (absence of bile in intestines).
    b. Severe intestinal disease interfering with absorption of vitamin K (sprue, gastrocolic fistula, ulcerative colitis).
      Treatment: Vitamin K and bile salts orally. Intravenous injection of phthiocol.
  C. Inability of liver to utilize vitamin K for synthesis of prothrombin.
    a. Prolonged obstructive jaundice.
    b. Severe hepatitis.
      Treatment: Vitamin K and bile salts orally. Intravenous injection of glucose. Administration of calcium salts. Feeding of gelatin.

III. Fibrinogen Deficiency.
  A. Acquired.
    a. Liver diseases.
    b. Nutritional deficiency diseases.
    c. Extensive destruction of bone marrow.
  B. Congenital.
    Treatment: Transfusion.

IV. Calcium Deficiency.
  No hemorrhagic disease known in which lack of calcium is the primary cause.

V. Antithrombins (heparin).
  a. Anaphylactic shock.
    Treatment: None indicated.

Traumatic Neurasthenia

By JOHN M. USOW, M. D.
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WITH the advent of the machine age and increasing speeds, there has been a proportionate increase in accidents, both automotive and industrial. This situation has brought to light a medical condition which the general practitioner is still inclined to feel forms a twilight zone. Patients falling in this category are obviously not well, and yet there are no such succulent and satisfying symptoms as rales, murmurs, crepitus, and positive laboratory findings.

The condition to which I refer is commonly called traumatic neurasthenia. It is a psychogenic, nonstructural nervous illness following shortly after an accident. In traumatic neurasthenia there is an acute neurosis of the neurasthenic type produced in a predisposed individual by a trauma. The actual physical injury itself may be negligible; it is the mental insult associated with it which does the damage.

Among the predisposing factors found most commonly, especially during these trying times, are economic distress, domestic conflict, monotonous work with insufficient periods of rest and recreation, preexisting hysteria or some intolerable situation, and personality defects.

From the organic standpoint many observers include syphilis, advancing age with cerebral vascular lesions, thymo-lymphatic states, and a certain amount of mental enfeeblement.

Traumatic neuroses, being compensable, are economically important. Afflicted patients usually come to the attention of the physician because they are claiming damages from some corporation or individual because

of their injuries. It is the physician's duty, both to the patient and society, to determine whether (1) the patient is malingering; (2) the extent of the patient's injury; (3) the degree of incapacitation; (4) the prognosis. In order to do this the attending physician must be familiar with the usual physical and mental symptoms following trauma, how they are commonly simulated and how simulation may be detected.

Symptomatology

The subjective symptoms of traumatic neurasthenia are headache, vertigo, and easy fatigability. The patient is sleepless and finds it difficult to concentrate his attention upon his work. A condition of nervous irritability develops, the patient becomes very hypersensitive to small annoyances of all kinds, and his entire mental attitude seems to change. He dwells constantly upon his condition, becomes low spirited, emotionally unstable, and fearful. He may even take to his bed and remain there for several months demanding that the household activities circulate around him. He may complain of numbness and tingling in the extremities, and in some cases much pain in the back which is shifting in character and aggravated by fatigue, excitement and digital pressure. The bodily functions may be well performed although such patients usually have for a time, at least, disturbed digestion and loss in weight.

Actual objective symptoms include a characteristic facial expression—a drawn, anxious, look. Pupils exhibit exaggerated light reflex and the pupils may be unequal, the large one being on the same side as the symptoms of pain or paralysis. Muscular force is only slightly impaired, but fatigue occurs abnormally early. There is a fine, rapid, regular tremor of the tongue, face and hands. The deep reflexes are markedly exaggerated, the superficial ones are diminished or lost. Disturbances of gait are common. The pulse may be irregular. More often, however, there is a tendency to tachycardia upon the slightest exertion. Vasomotor disturbances consist of cyanotic extremities, erythema of the face, neck and chest, and dermographia.

The above symptoms are not all present in any one case; they represent the possible manifestations of traumatic neurasthenia.

Differentiation

Many industrial physicians contend that patients who promptly recover following the award of damages are malingerers. This is by no means true. Neurasthenia generally improves after mental anxiety and worry are removed, and relief from these factors is in many cases as reasonable an explanation of recovery as the payment of the claim. Others contend they can tell by inspection of a patient whether or not he is malingering. This is not often possible unless the simulation is a rather clumsy one, and then in all justice to the patient an opinion should not be expressed on such meager grounds.

Hastily concluded opinions, such as those expressed above, are obsolete. Far more accurate means of detecting simulation have now been developed. Possibly the best known is the test for mental fatigue. The patient is given a newspaper and is told to strike out the letter "e" wherever it occurs in an assigned column. The real neurastheniac will start off with fairly good speed and accuracy and after a few minutes begin making mistakes which increase in frequency as the test is prolonged. At the same time there may appear accessory evidences of fatigue, such as perspiration, tremor, tachycardia and cerebral congestion. On the other hand, the malingerer, suspecting that a faulty showing is expected of him, begins to make mistakes from the first complaining that he "can't keep his mind on anything."

Headache, insomnia and vertigo form a nervous syndrome the nonexistence of which, some individuals feel, is hard to prove. Of the three, headache is perhaps the hardest to disprove. However, if the examiner stands by and permits the patient to describe his headache voluntarily he will note that the neurastheniac describes a feeling of pressure from within or without the skull. Vasomotor disturbances, such as flushing of the face and mucous membranes or alternate flushing and pallor, are often associated with an authentic headache. Insomnia can readily be detected by evidences of deranged nutrition, sometimes even ema-

ciation. If it is at all possible to hospitalize the patient this should be done; then he can be carefully watched. As for vertigo, a characteristic description of the neurastheniac is that the floor seems to be giving away under him and he is afraid. The malingerer, on the other hand, describes a whirling or turning sensation as he has previously heard that statement given as the description of vertigo. In the case of head injuries it is wise to examine the ear for evidences of vestibular irritation.

Tremor is hard to imitate, fibrillary tremor of certain muscle groups is almost impossible. Simulated tremors usually disappear with distraction.

Back pain can be detected best as the patient enters the room. The examiner will note rigidity of the back, a cautious groping walk, forward bending with a list to one side, sitting down with great care and rising by supporting the thighs. The absence of one or more symptoms points to stimulation or at least exaggeration.

The patient may attempt to simulate an exaggerated deep reflex, such as the knee jerk. However, if he is blind-folded the simulator anxious to show a response may do so without stimulation. Or, on the other hand, if the stimulation is present, the response may be definitely delayed.

So much for the methods of disclosing a malingerer. The literature presents many more methods too numerous to mention. Furthermore, the ingenious and conscientious physician will invent a few for himself as the occasion arises.

Prognosis

The majority of patients with traumatic neurasthenia recover from their acute illness. There is no doubt that their condition is aggravated during a long, tedious litigation. Financial settlement is often the starting point of recovery. However, if the patient feels that the settlement was too small he may become insulted and this psychic injury may aggravate his condition rather than cure him. On the other hand, if the award is greater than his expectation, he may still not recover, as he may feel that his ill health as judged by medical experts is greater than his own mind anticipated.

Patients who develop a traumatic neurasthenia are basically neurotic. Their acute illness is little more than an acute exacerbation of a chronic illness. Therefore, even when a settlement is made and the acute symptoms fade away the patient still remains neurotic, with many unsolved conflicts.

Treatment

Of universal value in the treatment of traumatic neurasthenia are numerous methods of reeducation, especially when speeded up by the aid of energetic suggestion (psychotherapy). Hypnotism, psychoanalysis and physiotherapy are all of use in properly selected cases. At times a short period of hospitalization is of great value. Almost all observers agree that claims should be settled promptly, and, if this is done prior to the instigation of prolonged litigation, it is one of the most valuable therapeutic aids.

Summary

(1) The incidence of traumatic neurasthenia is on the increase.

(2) It can be easily recognized by those who are familiar with the usual symptoms which follow trauma.

(3) Malingerers are decreasing in number as their inconsistencies become recognized by conscientious examiners.

(4) The prognosis is usually good in acute illnesses if the claim is adjusted quickly. However, it must be remembered that traumatic neurasthenia is an acute exacerbation of a chronic condition which still needs treatment.

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Preoperative and Postoperative Treatment of Toxic Goiter*

By ARNOLD S. JACKSON, M. D.
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ALTHOUGH the preoperative treatment of exophthalmic goiter and toxic adenoma is essentially the same, the results of treatment may be considerably different. Iodine which has come to replace weeks of bed rest, multiple operations, x-ray therapy and even digitalis in the pre-thyroidectomy period of exophthalmic goiter, will perform no such miracles in toxic adenoma. In a study of 279 cases of toxic adenoma, presented at the American Medical Association meeting in 1936, I found that iodine was either beneficial or had no effect in 62 per cent of the patients, while 38 per cent were made worse.

This is in marked contrast to the effect of iodine in exophthalmic goiter, practically every case of which is improved by iodine, unless the drug has been previously administered over a long period of time. This danger is now generally recognized and the so-called iodine fast case of exophthalmic goiter must be regarded as entailing the same risk as the advanced case of toxic adenoma.

While 38 per cent of the cases of toxic adenoma may be made worse by iodine and a considerably larger number show no effect whatever, it is safer to administer iodine preoperatively to all patients having toxic goiter. If iodine is given for no longer than a week or ten days preoperatively, little harm will result if the case is one of toxic adenoma. On the other hand, if an error in diagnosis is made, as, for example, in a case in which an exophthalmic goiter is superimposed upon a simple adenoma, then a postoperative crisis will be averted by the preoperative use of iodine.

Since The Journal is largely concerned with the problems of the general practitioner, it might be well to consider the best plan for such a practitioner to follow when confronted with a suspected case of hyperthyroidism. Obviously to start administering iodine in a doubtful case is wrong, since the diagnosis may become even further confused. If at all possible, he should, after obtaining a careful history and physical examination, have a basal metabolism test made. If the latter is accurate, it may prove helpful in clearing up the diagnosis and in the preoperative preparation. If it is inaccurate, as unfortunately is so often the case, it may serve only to confuse the diagnosis. An almost immediate favorable response to iodine with a drop of twenty points or more in the metabolic rate within a week to ten days is strongly suggestive of exophthalmic goiter. In some instances, however, the patient may be only slightly benefited and this may be due to one of two reasons; (1) exophthalmic goiter is not present, or (2) it may be present but the benefit of the iodine may have been offset by failure to have proper rest.

In any event, it is well not to continue iodine for longer than ten days unless the patient is extremely toxic, emaciated or has a typical toxic adenoma. The dosage of iodine is not of great importance, but in the ordinary case I give ten drops of Lugol's solution three times daily, well diluted in water, milk or grape juice. In very toxic cases of exophthalmic goiter this amount is doubled, although theoretically smaller doses are sufficient.

Building the patient up for operation is of the utmost importance in the successful treatment of toxic goiter. At one time I was required to operate upon my niece and in a period of twenty days she was able to gain twenty-one pounds. In toxic adenoma, however, such results are not seen. A high caloric diet of 3,000 or more calories, given in frequent lunches, is advisable.

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* From the Jackson Clinic. Presented at the 97th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1938.

No patient should be kept continuously in bed preceding operation but should be allowed to build up his strength as soon as such complications as cardiac decompensation are controlled. Patients should be encouraged to walk about freely, but should avoid undue exertion and should spend part of their time resting. Many patients can be prepared at home as well as in a hospital, but this is not always true.

The question of digitalis is still a debatable one and whether the patient is digitalized or not appears to make little difference in the majority of cases. Certainly iodine appears to do more than was once hoped for from digitalis in exophthalmic goiter. Nevertheless, I have continued to use it routinely, and in the critical cases of toxic adenoma I have never been convinced that it is harmful.

The only sedative I use either before or after operation is phenobarbital in small doses. However, 2 per cent of patients with hyperthyroidism have an idiosyncrasy to this drug and it may be necessary to substitute some other mild sedative.

Obviously, in a discussion as short as this, it is impossible thoroughly to cover this large subject, but to me far more important than the question of drugs is the psychology of handling these nervous persons. One must endeavor to gain their confidence right from the start and to instill in them the assurance that they will recover just as many others have. It is a mistake to discuss the subject of operation when the patient is first seen; rather this should be postponed until his condition is so improved that he no longer dreads the ordeal. In the handling of these patients, the utmost tact and diplomacy is required of all who come in contact with them and in this respect a great deal can be done by the family physician. Patients should be spared worry, annoyance, disagreeable subjects, loud noises, etc. The state of mind in which they go to the operating room may have a great deal to do with the success or failure of the operation.

In the immediate preoperative care, my patients receive a glucose orange juice highball, forty drops of iodine, five grains of sodium barbital, one-third grain of pantopon and grain one-one hundred fiftieth (1/150) of scopolamine. Grain one-two hundredth (1/200) of scopolamine is used in persons over 50 years of age. The patient's eyes, ears and head are covered one hour before operation, and the room is kept quiet and dark to permit the sedative to become effective.

No attempt is made to steal the gland but rather the patient is fully informed as to the time of operation, once his confidence is assured.

When the patient is returned from the operation, it is important again that his room be quiet and free of relatives and visitors. If he has an exophthalmic goiter, it is essential that iodine be given at once and continued in sufficient doses to control all symptoms of hyperthyroidism. It may be given in doses of five or ten drops and in total amounts up to 150 or 200 drops if necessary in twenty-four hours. If the patient is brought under control within the first few hours, the iodine may usually be given in ten-drop doses every

Fig. 1.—As a rule, the risk of surgery in children with exophthalmic goiter is greater than in adults and requires special attention to the preoperative and postoperative care.

Fig. 2.—The appearance of this patient with exophthalmic goiter is deceptive. He has lost seventy-five pounds and will require most careful preoperative and postoperative care.

hour. It has been my misfortune to see several patients with exophthalmic goiter die because some intern or nurse did not understand or neglected the giving of iodine as required. When it is not tolerated well by mouth, it may be given by proctoclysis, by the subcutaneous route, by duodenal feeding, or even intravenously. Above all things the patient must be made to understand the importance of retaining the iodine. When it is continually emessed, the pulse begins to speed up, the temperature climbs, the patient becomes restless and finally delirious. To combat such hyperthyroidism, the iodine intake must be increased, and an ice bag should be added for each degree of fever. The latter may also be lowered by subcutaneous saline, cooling enemas and oxygen. Pantopon and phenobarbital usually suffice as sedatives.

Patients with toxic adenoma seldom require over thirty drops of iodine a day postoperatively. They present a different picture, one that is nearly always satisfactory the first day or two. Then if the outcome is unfavorable, they become restless, there may be a twitching of the extremities as if from cerebral irritation. The pulse becomes weak, thready and irregular, and the patient gradually lapses into a stupor, coma and death. So far as I know, a means to prevent this is yet to be found. Performing a lobectomy rather than a thyroidectomy is the best safeguard in elderly patients with toxic adenoma.

In the convalescent period every effort should be made to encourage the patient to gain weight and strength. If the patient with exophthalmic goiter fails to do this, he may have a persistence of the disease or later develop a frank recurrence. The use of iodine may be discontinued in a few days in the cases of toxic adenoma as recurrences rarely develop. In Graves' disease, however, it should be continued for at least three

Fig. 3.—Exophthalmic goiter complicated by pregnancy, as in this case, may require a two stage thyroidectomy. Preoperative and postoperative care are very important in the successful handling of these patients.

months. Patients should be warned against resuming strenuous duties too soon and every effort should be made to protect the patient with exophthalmic goiter from developing a recurrence. The care of the heart in both types of goiter is important and it is essential that the family physician require the patient to report to him at regular intervals to see that proper rest and therapy are continued.

Some patients tend to gain too much weight and they should be protected against this. Those who remain underweight should be given a high caloric diet, tonics and vitamins.

The success or failure in the outcome of any operation for toxic goiter may well depend upon the proper preoperative and postoperative care and consequently upon the close cooperation of the family physician and the surgeon.

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Primary Tuberculosis of the Cervix; A Case Report*

By JOHN A. TASCHE, M. D.
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PRIMARY tuberculous infection of the female genital organs is rare. Not more than thirty cases of the disease have been reported in the literature. It can only be known as such when there is proof that tuberculosis does not and never did exist elsewhere in the body. It must come from without the body of the host. Infected fingers and instruments may be causative factors. Or infection may be introduced by the penis of an infected male during coitus. Unless the seminal vesicles and prostate are infected, the seminal fluid is usually thought not to carry the infection. In the case report to follow, the focus of infection was found to be in the prostate of the husband.

Case Report

Mrs. K. D. appeared in my office March 20, 1933, with a complaint of bloody vaginal discharge. The bleeding occurred at any time following coitus. This condition had apparently existed for some months prior to her first visit to my office. She had lost twelve pounds in weight during the preceding three months. She had no other complaints and stated she felt well.

History.—Past medical history revealed no serious injuries or illnesses, other than cholelithiasis, in 1923, which was corrected by my father. He performed a cholecystectomy and appendectomy. There was no evidence, according to my father, of tuberculosis anywhere in the body at the time of surgery. The pelvic organs were examined and no abnormality was found. In 1925 her tonsils were removed because of recurrent tonsillitis. X-ray study of the chest at that time disclosed nothing abnormal.

The patient had begun to menstruate at the age of 17 years. Her periods were regular, appearing every twenty-eight days and being of five to six days duration without pain or clots. She had never had any leukorrhea.

She had had two children. My father confined her both times; delivery and puerperium were uneventful. At the time of her examination the children were 24 and 26 years of age, respectively. They were both well.

The family history was largely negative. There was no history of tuberculosis in any member of her family, other than her husband. It was, however, very interesting to note that her husband was being treated for tuberculosis of the prostate by a local urologist. He did not have pulmonary tuberculosis.

Physical findings.—Physical examination revealed a well developed, well nourished, white female, 47 years of age, who did not appear acutely ill. Examination of the head, neck and chest were negative; there was no evidence of focal infection or tuberculosis. The abdomen was soft, no masses, tenderness or hernia were found. There was a long linear scar in the right upper abdominal quadrant.

The vulva and perineum were normal. A few small hemorrhoids were found. There was also slight cystocele and rectocele. The vaginal mucous membrane was normal. The cervix was in the centrum and the size of a half dollar. On the anterior

* Condensed from a paper presented at the 97th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1938.

Fig. 1. Low power magnification. Section through base of tuberculous ulcer showing two tubercles.

wall there was an ulcer about the size of a dime. Its edges were dark red, ragged and seemed to be undermined. The ulcer bled freely on manipulation and was filled with a grayish membrane. The Schiller iodine test was negative, that is, the iodine solution did not stain the ulcer. On examination with the Hinselmann colposcope, the colposcopic picture was found to fit that of any early endophytic type of cervical epithelioma. The uterus was not enlarged; it was anteflexed and mobile. The perimetrium was not thickened. The tubes and ovaries were clear.

Other physical findings were normal.

Laboratory findings.—Laboratory tests revealed a normal blood picture, normal urinalysis and a negative blood Wassermann reaction. X-ray examination of the chest revealed no evidence of tuberculosis. No biopsy was performed in that a diagnosis of early ulcerative carcinoma of the cervix seemed obvious.

Treatment.—Radical panhysterectomy, after the method of Wertheim, was agreed on as the treatment of choice. Therefore, on March 26, 1933, I performed a radical Wertheim panhysterectomy. The intra-abdominal pelvic organs were found to be normal. There were no adhesions and no evidence of tuberculosis. The patient made an uneventful recovery, and was discharged from the hospital as recovered on April 21, 1933.

Pathologic reports.—A careful and detailed study of the tissues removed at the operation was made by two well-known pathologists, independently of each other. An early adenocarcinoma of the corpus uteri was found by each, as was tuberculosis of the cervix. The tuberculosis was found to be confined to the anterior lip of the cervix, which was preoperatively diagnosed as an early ulcerating carcinoma. There was no evidence of tuberculosis in the tubes, ovaries or uterus.

The postoperative diagnosis was primary tuberculosis of the cervix and early adenocarcinoma of the corpus uteri.

Course.—The patient reported to me for examination every three to four months thereafter. There was never any evidence of recurrence of either tuberculosis or carcinoma. I examined her last on September 1, 1938, and found her to be in excellent physical condition. There was no evidence of recurrence of her old ailment. Permanent cure can, therefore, be assumed after a lapse of five years and six months following surgical treatment.

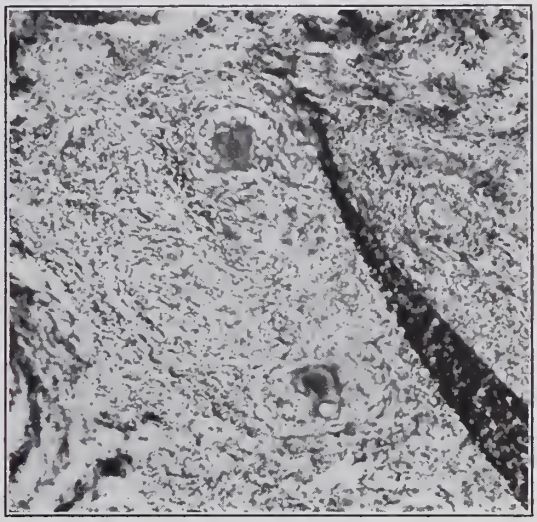

Fig. 2. Low power magnification. Section through tubercles below those shown in Fig. 1. Typical giant cell formation of tubercles can be seen.

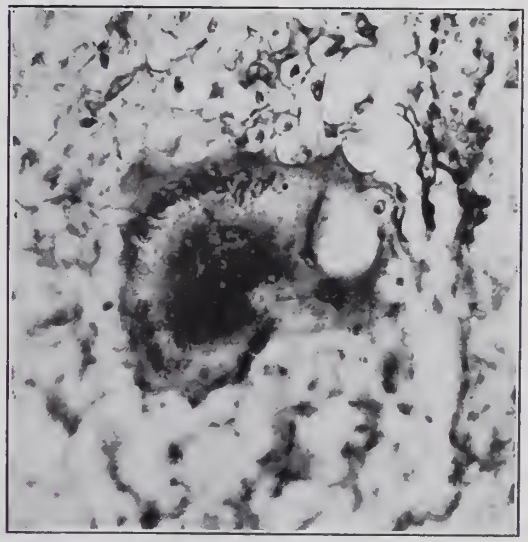

Fig. 3. High power magnification. Section through tubercle at base of ulcer of cervix, showing typical giant cell formation.

Endocrine Preparations of Proven Therapeutic Value*

By JAMES H. HUTTON, M. D.
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AS MOST physicians engage in some general practice and all are confronted by many cases having an endocrine factor, I shall address my remarks to the general practitioner. I assume that most of you do not have access to elaborate laboratory facilities and further that most of your patients could not pay for them if you had; consequently no laboratory procedures will be mentioned.

As only a few of the most important features of this subject can be touched upon in the allotted space, this presentation will necessarily be rather sketchy and elementary.

General Statements and Classification

The basal metabolic rate tells nothing as to the dose of thyroid the patient may need. Neither does the finding of a low basal metabolic rate make a diagnosis of hypothyroidism. Hypoadrenia and hypopituitarism exhibit rates quite as low as those found in hypothyroidism. The easiest differentiation is by therapeutic test. Victims of either hypoadrenia or hypopituitarism, when given sufficient thyroid to elevate their basal metabolic rate to normal, feel much worse, whereas the victims of hypothyroidism feel much better.

Every physician should become acquainted with one or more preparations of thyroid and stick to those that he knows. The dosage must be determined by trial, beginning with a dose of one grain or less per day and increasing the dose about every fifth day until that point is reached which produces tachycardia, tremor, nervousness, irritability or a rise in temperature; it should then be reduced about 25 per cent below that point and continued at that level.

All endocrine deficiencies except severe hypoadrenia and eunuchoid hypogonadism are better treated if, to the specific medication, thyroid is added in doses just short of the patient's tolerance.

The old contention that endocrine disturbances should be viewed as monoglandular affairs can be forgotten. It is now generally recognized that practically all endocrinopathies are pluriglandular by the time they reach the attention of the clinician.

In discussing the treatment of certain conditions herein, only the endocrine features will be mentioned, but it is understood, of course, that conditions such as sterility and impotence, for example, may have other than endocrine factors.

The endocrinopathies of childhood are much alike in the two sexes and require the same medication. From puberty to the age of 50 years the most common endocrine dyscrasias are those involving the sexual apparatus. The general therapeutic preparations needed are the same in both sexes. Special needs are the estrogenic and male hormone preparations.

Childhood endocrinopathies
- Thyroid deficiency
  - Cretinism
  - Less severe forms
- Growth deficiencies
- Froehlich's syndrome
- Acne vulgaris

Male endocrinopathies
- Cryptorchidism–undescended testicle
- Impotence
- Sterility
- Prostatic hypertrophy

Female endocrinopathies
- Gonorrheal vaginitis
- Delayed puberty
- Amenorrhea–oligomenorrhea
- Dysmenorrhea
- Menorrhagia
- Frigidity
- Sterility
- Habitual abortion
- Failure of lactation
- Menopause
- Premenstrual migraine

Endocrinopathies beyond middle life
- Hypertension
- Diabetes mellitus

* Presented at the 97th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1938.

For the treatment of these disorders we have such a host of endocrine preparations that no man can be thoroughly familiar with all of them, yet they fall into a few classes which can be easily remembered. From these one can make the proper selection with little difficulty. The chief ones are listed below:

(1) *Pituitary Preparations*
- For oral use
  - Whole pituitary
  - Anterior lobe
- Posterior lobe extracts
  - Pituitrin and similar extracts
  - Pitocin
  - Pitressin
- Anterior lobe
  - Whole extracts
    - Antuitrin and others
- Sex hormone
  - (Gonadotropic)
  - Prephysin
  - Gynantrin
  - Maturity factor
- Growth hormone
- Adrenotropic
- Lactogenic

(2) *Pituitary-like preparations*
- (Gonadotropic)
- Antuitrin–S
- Follutein
- Antophysin
- A. P. L.

(3) *Estrogenic preparations*
- Ovarian residue
- Ovarian substance
- Agomensin
- Sistomensin
- Theelin
- Amniotin
- Progynon
- Ovarian concentrate
- Emmenin

(4) *Corpus luteum hormone*
- Lipo-lutin
- Proluton

(5) *Male sex hormone preparations*
- Oreton (Schering Corp.)
- Perandren (Ciba)

Childhood Endocrinopathies

Growth deficiencies.—For growth deficiencies we have thyroid, to be given as already described; anterior lobe, to be given by mouth in doses of 2.5 grains and upward three times a day; and anterior lobe extracts or growth hormone preparations, to be administered hypodermically. The anterior lobe extracts may be given in doses of 0.5 to 1 cc., and the growth hormone preparations in doses of 1 cc. or more, twice a week. Occasionally when the response is not satisfactory to either of the above pituitary preparations, the gonadotropic preparations may be given in doses of fifty units three times a week.

Froehlich's syndrome.—Treatment of Froehlich's syndrome consists of giving thyroid; whole pituitary by mouth in doses of 1 to 3 grains three times a day; posterior lobe extracts in such doses as the patient can tolerate without intestinal cramps; anterior lobe extracts 0.5 to 1 cc. twice or thrice weekly; and growth hormone preparations in the case of those lacking in stature, when there is failure to respond to anterior lobe extracts. In those of normal stature or above, the gonadotropic preparations may be given instead of the extracts of the anterior lobe. The dose should be fifty units two or three times per week.

Acne vulgaris.—Gonadotropic preparations have been found effective in a considerable percentage of cases of acne vulgaris.

Male Endocrinopathies

Cryptorchidism.—Patients with cryptorchidism may tolerate very small doses of thyroid. Opinions differ as to the correct dosage of the gonadotropic preparations. My own preference is for a fifty unit dose given two or three times a week for two weeks, doubled at the end of that time if there are no signs of improvement, and doubled again at the end of a month. It is sometimes necessary to give 200 or 300 units twice a week. Occasionally anterior lobe extracts succeed where the gonadotropic preparations fail. If a child is obese, posterior lobe extracts should be used. Male sex hormone preparations may be used in doses of 2.5 to 5 mg. twice a week when the genitalia have failed to attain normal size, but they should be used only after the gonadotropic preparations have brought about descent.

Impotence.—Use thyroid cautiously in cases of impotence. Gonadotropic preparations may be used in doses of fifty to 100 units twice or three times a week. After the age of 45 years, these latter preparations should be used with extreme care.

Male sex hormone preparations in doses of 5 to 10 mg. two or three times a week are helpful. Extracts of the anterior lobe are sometimes quite as effective as the gonadotropic preparations. Extracts of the posterior lobe should be used in the obese.

Prostatic hypertrophy.—Considerable benefit has been reported following the administration of large doses of orchic substance by mouth.[1] The equivalent of about 900 grains of the fresh gland was given daily. Symptomatic relief is also reported to have followed the administration of male sex hormone in doses of 5 to 10 mg. three times a week. There is some question as to whether the size of the prostate was actually reduced by this treatment. There seems general agreement that symptomatic improvement occurs in most cases. Posterior lobe extracts are helpful in the obese.

Sterility.—In treating sterility in both sexes one may use thyroid; gonadotropic preparations; or extracts of the anterior lobe.[2] In the male, the male sex hormone may be useful; in the female, estrogenic preparations are of value.

Female Endocrinopathies

Gonorrheal vaginitis.—This condition in young girls is reported to be successfully treated in most cases by the use of amniotin suppositories or amniotin injections.[3]

Delayed puberty. Amenorrhea-oligomenorrhea.—For the treatment of these conditions we have thyroid; estrogenic preparations, which should be used in rather small doses, not in excess of 2,000 units three times a week; and the gonadotropic preparations, fifty units to be given three times a week. These latter two preparations can be given alternate months, alternate weeks, or alternate days. Posterior lobe extracts are helpful in the obese.

It should be remembered that practically all menstrual disorders of early years are associated with, if they are not actually due to, a disturbance of the pituitary sex hormone and that their treatment will require, in 90 per cent of the cases, the use of some gonadotropic preparation. As the years increase, the pituitary involvement decreases in frequency and importance; consequently the estrogenic preparations increase in importance with increasing years.

Low dosage irradiation over the region of the pituitary and ovaries is often successful when other measures fail.

Dysmenorrhea.—For the treatment of this condition there are thyroid; estrogenic preparations, particularly useful in young women in whom the uterus is undeveloped; gonadotropic preparations; and the corpus luteum hormones, as Lipo-Lutin or Proluton, in doses of 0.2 to 1 unit twice a week beginning ten days before the expected menstrual period. Low dosage irradiation, as indicated above, often brings relief.[4]

Menorrhagia.—In menorrhagia we may give thyroid, and gonadotropic preparations in doses of 100 to 300 units daily until the flow is stopped. Corpus luteum hormone is sometimes effective, and less often, sistomensin is helpful in doses of two ampoules daily. In the treatment of this condition much larger doses of the gonadotropic preparations are needed than in the treatment of other menstrual disorders. In irradiating the pituitary and ovaries, larger doses may be needed than in the treatment of other menstrual disorders. Except in women who are almost at the menopause, extreme care should be taken lest the periods be permanently stopped and an early menopause induced.

Frigidity.—Thyroid is not often helpful, but it should be tried cautiously. Extracts of the anterior lobe or gonadotropic preparations plus estrogenic preparations in doses of 2,000 units three times a week are beneficial. In older women the estrogenic preparations will be needed more often than in young women.

Habitual abortion.—Corpus luteum preparations are probably the most effective endocrine agent at our command for the treatment of habitual abortion.

Failure of lactation.—For many years clinical endocrinologists have known that female victims of pituitary deficiency could not nurse their babies and that following the correction of this deficiency they were able to nurse succeeding babies. Since Riddle and his coworkers[5] gave us prolactin, the lactogenic hormone from the pituitary, the

treatment of this disorder can be carried out much more successfully. In the cases thus far reported the majority have been helped by injections of this preparation.[6]

Premenstrual migraine.—Many victims of pituitary deficiency give a history of headache occurring from two to ten days before the menstrual period, associated with chilliness and a craving for sweets. Such cases can usually be relieved by extracts of the anterior lobe, the gonadotropic preparations in small doses (50–75 units) or emmenin.

The menopause.—Thyroid should be given cautiously; and posterior lobe should be given only in cases of obesity. The gonadotropic preparations should not be used. The symptoms are controlled in the vast majority of cases by adequate doses of the estrogenic preparations, such as theelin, amniotin, progynon, etc. In my experience 2,000 units three times a week is sufficient in the vast majority of cases, although much larger doses up to 50,000 units two times a week are recommended by some men.[7] I am opposed to these large doses because they are unphysiologic and, I think, unscientific. The body never makes any such quantities for itself and it seems to me that we are unwise to impose upon it what it does not make for itself even in a state of health.

When the standardized estrogenic preparations, such as theelin, amniotin, progynon, etc., are not effective, the symptoms are sometimes controlled by preparations derived directly from the ovary, such as ovarian substance, agomensin and sistomensin. I have seen them controlled even better by ovarian concentrate given by mouth.

The symptoms of the menopause are often controlled by x-ray therapy, applied to the regions of the pituitary and ovaries and the results are better if the pituitary and adrenal regions are treated as well as those of the pituitary and ovaries. Many symptoms of the menopause are due to dysfunction or hyperfunction of the pituitary and adrenal glands, consequent on withdrawal of the inhibitory influence of the ovaries. Consequently depressing or regulatory factors applied to these organs are many times successful in relieving symptoms. The factors used and the dosage employed vary with different physicians.

Endocrinopathies Beyond Middle Life

Members of both sexes are victims of hypertension and diabetes with increasing frequency after the age of 50 years. There is a large mass of evidence pointing to a dysfunction of the pituitary and adrenal glands as the causative factor in some cases. The last five or six years we have been treating patients with these disorders by low dosage irradiation to the pituitary and adrenal areas. Our results are shown in tables 1 and 2. Results obtained by other workers with this type of treatment are shown in table 3.

TABLE 1.—*Results of Low Dosage Irradiation Therapy in 354 Patients with Hypertension*

Adequately treated			268
Improved	186	69.4%	
Relapsed	29	10.8%	
Remained improved	157	58.6%	
Unimproved	82	30.6%	
Insufficient treatment			59
Unable to follow up			27
			354

TABLE 2.—*Results of Low Dosage Irradiation Therapy in 34 Patients With Hypertension and Diabetes*

Improved as to both	13
Improved as to hypertension only	7
Improved as to diabetes only	4
Improved but relapsed	1
Unimproved	2
Insufficient treatment	6
Unable to follow up	1
	34

TABLE 3.—*Results of Low Dosage Irradiation Therapy in 275 Cases of Hypertension Reported by Various Authors*

	Number of Cases	Number Improved
Martin	100	80
Baker	40	30
McGuffin	40	30
Boswell	12	11
Finch	12	9
Konantz	6	3
Parkhurst	5	3
Hadley	4	4
Miscellaneous	56	47
	275	217

Undoubtedly we have failed to take advantage of physical agents as frequently as we should. For more than a decade low dosage irradiation has been applied to the pituitary body or to it and the ovaries in the

treatment of all kinds of menstrual disorders. The treatment seems to be equally effective in amenorrhea and menorrhagia. No bad effects have been reported following this treatment. Women who have been subjected to it have become pregnant and born healthy children.[8] Our own experience is that it is a good many times entirely effective in the treatment of amenorrhea when estrogenic and gonadotropic preparations fail.

Low dosage irradiation to the pituitary and adrenal glands in our experience has provided symptomatic relief of headache, vertigo, tinnitus, irritability, nervous tension, and precordial distress in 90 per cent of our patients with hypertension[9]. This has been true even when there was no reduction in blood pressure.

In the dosage we have used there is not the slightest danger of causing any damage to any structure.

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Comments on Treatment

EDITORS

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and

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Pinworm (Oxyuris Vermicularis)

Among the most common intestinal parasites encountered are pinworms also known as thread- or seatworms.

The infestation occurs mostly in infants and children although it is occasionally found in an adult. While the pinworm does not injure its host or produce any pathological lesions, it does cause a number of annoying symptoms. The most serious is appendicular colic which is caused by the entrance of the worms into the depths of the appendix. But the most common disagreeable effects are the cutaneous irritation and itching brought about by the migrating female worms crawling out of the anus. The intense pruritus often causes disturbance of sleep, marked discomfort, and nervous irritability. Due to scratching, secondary local dermatitis may result.

The diagnosis is usually fairly easy. A history of severe itching about the anal region should immediately arouse one's suspicions. A positive diagnosis is made by finding ova in the stools or in scrapings from the perianal region. Occasionally one can actually see pinworms emerging from the anus.

Treatment of this infestation is difficult. Numerous failures may be expected. The key to success is cleanliness. It must be remembered that the pruritus caused by the crawling and biting of the gravid female

causes the child to scratch and in doing so contaminates his hands with ova. When the eggs are carried to the mouth, reinfestation takes place and thus the cycle is repeated indefinitely. Every effort must be taken to prevent this transfer of ova. The hands of the child must be frequently scrubbed, and the nails kept short and scrupulously clean. To keep the child from scratching during the night, it may be necessary to put on gloves or to tie the hands. The anal region and the perineum should be thoroughly cleaned with soap and water, and then covered with a 2 per cent ammoniated mercury ointment. After every bowel movement, the anal region should be cleansed and fresh ointment applied. Heavy drawers closed in front and back will prevent the child from reaching the infected area. Clothing and bedding should be frequently changed and washed. To control the pruritus, a 5 to 10 per cent ointment of ethyl aminobenzoate (benzocaine) can be used.

The most popular drug for internal use at present is hexylresorcinol. For children 0.6 to 0.8 gm. is given five hours after a light meal. This is followed by an enema of an alkaline solution of hexylresorcinol (0.1 per cent). Formerly santonin and oil of chenopodium were used more widely. While these drugs are fairly effective, their toxicity should make one hesitate to use them except in cases which have resisted other therapy. In adults santonin (1 to 1½ grain) followed by calomel and magnesium sulfate purge has at times given surprisingly good results.

Rectal irrigation by means of medicated enemas still retain their place in therapy. A 1 to 5 per cent aqueous infusion of quassia is often employed. The alkaline hexylresorcinol enema has already been mentioned. Perhaps the warm soapsuds enema is as effective as any other. A. J. Q.

Wisconsin Supreme Court Holds Optometry a Mechanical Art, Not a Profession

IN A CASE arising out of efforts of the Milwaukee Optometric Society to prohibit an optometrist from so-called corporate practice under the Kindy Optical Company, the Wisconsin Supreme Court on June 4 reversed the decision of the circuit court of Milwaukee and held that optometry not being a profession, corporate practice was legal. In its opinion Wisconsin's high court stated in part that:

"Optometry is readily distinguished from a profession in the practice of which diseases of the eye are treated."

"It is a mechanical art * * *"

" * * * optometry is not a part of the practice of medicine."

"An optometrist can be an employe."

"Our legislature has dealt with optometry as a skilled calling, not as a profession, not as a profession involving a relation of special confidence between practitioner and patient."

The Court's Opinion

The full opinion of the court follows:

FAIRCHILD, J. Unless the appellant offends against the law by employing licensed and registered optometrists to assist in its business of serving its customers by adjusting glasses to their eyes, there is no ground for the complaint against it. It admits that it does employ two licensed optometrists in its business. It furnishes them certain devices and machines to be used by them, and it sells lenses to persons on prescriptions written by those employes. Where glasses are found to be required, the prescription is made out and filled in the store of the appellant, but the price charged for the glasses is no more than where an examination is made by an optometrist not in appellant's employ. Appellant has pursued this method in the sale of optical goods for many years. There is no claim that when it began doing so prior to 1915 there was any legal objection to be interposed to that conduct.

In view of the conclusion upon the meaning of the statute, it is unnecessary to consider the effects of the judgment entered in the Dane county circuit court upon the present proceedings.

The law regulating optometry (now Ch. 153) was passed in 1915 (Ch. 488, Laws of 1915). Sec. 12 of that chapter read in part: "every person, firm or corporation engaging in the practice of optometry shall . . . " In 1923 by a revisor's bill that portion of sec. 12 just quoted was made to read "everyone practicing optometry . . . shall . . . " This change was accompanied by the revisor's statement of its

(Continued on page 572)

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« « « EDITORIALS » » »

Time to Call a Halt?

INCREASINGLY during the past ten years forces of all types have sought to take advantage of the propaganda drive for compulsory sickness insurance, in order to advance self-interests. And increasingly during this period of time a Medicine that stands firm in the interests of its patients has heard in legislative halls and out of them the demand that it retreat from its present position, and the implied threat that failure to retreat will only hasten the day of "state medicine," "socialized medicine," or something else equally unpleasant for Medicine.

If this were the fact and the unpleasantness concerned were for Medicine primarily, or for Medicine alone, the argument conceivably might have some weight. But Medicine stands firm in its position, because its position is based on what will best protect and further advance the high health achievements of the citizenry of this State and the Nation as a whole.

Heretofore such demands and threats have been used by the chiropractors, the osteopaths and the propagandists of this or that allied source. But we were frankly astonished a few weeks ago to see the campaign manager of a hospital, seeking additional subscriptions in order to erect a nurses' home, quoted in the press as saying that the physicians' team seeking subscriptions had failed to meet its quota and that unless medical problems were met adequately "state medicine and state control of hospitals may replace the present system of hospitalization and medical care."

Throughout the years it has been the physician who has said to his patient in need of hospitalization, "Pay the hospital first; we will take care of my services later."

Demands and threats to Medicine may be expected from cultists and propagandists, but when they come from a source such as that described, is it not time that Medicine made its position firmly and forcibly understood? Is it not time to challenge the shallow thinking of this type of statement whenever and wherever it is made? *Is it not time to call a halt?*

. . . . THE PRESIDENT'S PAGE . . . .

DURING the months of May and June the medical schools of our country have been disgorging themselves of the senior classes. The graduate hastens into hospitals, to serve as it were an actual and active apprenticeship, in his future calling. His mind is troubled as to whether he will be a success and he has had just enough medicine to begin to wonder whether he might not be a square peg trying to fit into a round hole. After this year some of them will have enough self-confidence to believe they can conquer the earth and, upon the other hand, there will be those who will wonder to their dying day whether they were designed to be doctors in the best accepted definition of the word. (After a long practice, I still wonder about my own position in medicine. And there are many of us in practice who wish we could start all over again with a new slate.)

One of the "strange interlude" came into my office yesterday and told me he was going to intern for a year and then take a residency for another. He said, after that, he wanted to do his own appendix and hernia operations. Gently, very gently, I told him that after all there are times when the removal of an appendix is one of the most difficult of surgical procedures. And as to the operation for hernia, a condition so lightly considered by the recent graduate and the public alike,—that is a task that really requires anatomical knowledge and surgical skill. But youth is exuberant. One must not dampen it. Time erodes the ego of most of us. (In my own case it was only a few years ago that I came to realize one of my younger men could tie a knot as well as I myself.)

For the next several months the recent graduate will concern himself as to what specialty he will follow. (And there will be those in the land crying as loud as ever that the general practitioner has gone with the horse and buggy and the dodo bird. It is a libel,—the general practitioner has never been away. He still forms the main line of defense of American medicine. After the patient has been buffeted about among the specialists he will at last come back into the hands of the general practitioner and there have his bodily ailments evaluated as a whole.)

For some reason or another I have never been in accord with the modern idea of turning out graduates as specialists some three years or less after graduation. I think that it takes some years of practice to make a specialist and to acquire the most valuable asset of all,—judgment. I am heartily in favor of the specialist, as such, but I think his proper position should be that of a consultant to whom the general practitioner can refer, for treatment and operation, those of his patients who need specialized service. In these days, however, every man is his own specialist. The public, nevertheless, is catching up somewhat on the modern trend of medical education; and public clamor will do much to straighten out any of the rough spots.

There awaits an opportunity in this state for every man who has practiced a number of years to help guide these young men in medicine over the first anxious years. It not only affords a position of honor and respect; it is duty as well. Perhaps we have not made as much of it in the past as we might have. If we older men could make the recent graduate see that in most cases the current expression "sticking your neck out" is just a fetish of timid men; if we could instill into him the fact that one conviction is better than many opinions; if we could teach him that this question of "personality" is in many cases the armor of quacks; and if we could gently teach him that the ability to get along with other people is perhaps one of the greatest things in life,—then we would have accomplished something, something that would help him and, in doing so, help us.

I cannot avoid the feeling that the place for the recent graduate, as soon as he has definitely located, is in the County Medical Society. It is here that he is thrown intimately with the older men, the leaders of the community, and it is here that he learns what is common custom in his particular locality.

And so during the summer keep an eye on the young man locating in your community. Help and guide him whenever the opportunity presents itself. Then in the fall when the county society activities begin again, tell him of the advantages to be gained by his identification with it. Of all the professional organizations that I can think of, the organization of American medicine has done the best job in uniting, for carrying out the ideals of medicine, protecting the public and disciplining its own members in the public interest.

R. G. Arrum

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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Organization

By MRS. E. S. SCHMIDT
Green Bay

EARLY in the year letters were sent to the presidents and secretaries of seventeen of the county medical societies in which a woman's auxiliary had not been organized. No reply was received from the officers of seven of these counties. The distance between towns in the northern part of the state with the resultant infrequency of meetings was one of the many reasons for the refusal of the county societies to vote favorably on our request for permission to organize.

On May 28 a Woman's Auxiliary to the Sauk County Medical Society was organized. Three other county medical societies have the question under consideration, and we hope to organize these groups before the state meeting in September.

There are at present twenty-seven auxiliaries with a paid-up membership of 1,139.

In reply to a number of inquiries from prospective members and physicians as to the need and value of an organization of doctors' wives, I have outlined the aims and purposes of the auxiliary as follows:

1. To encourage friendliness among doctors' families and to assist in entertainment at county and state medical society meetings.
2. To extend the aims of the medical profession for the improvement of public health and the advancement of health education to other organizations in the community.

3. To do such work as may be suggested from time to time by the county medical society. The auxiliary does not undertake a project until it has been approved by an advisory council chosen from the membership of its own county medical society. In this way, there is no danger of the organization becoming

over-ambitious and undertaking projects that run counter to the aims of the medical society.

4. To assist in placing speakers from the county medical society on the programs of women's clubs, church circles, parent-teacher associations, and other groups, and thus to establish an entree into the programs of these organizations for the dissemination of information on problems relating to the promotion of public health and social welfare.
5. To become well-informed on the problems of the medical profession and its relation to the public. Information thus acquired enables members to present intelligently to the lay public the point of view of the organized medical profession. Some auxiliaries have literary groups which devote time each month to the reading and reviewing of books written by doctors or about doctors.

I have been assisted in the work of organization by Mrs. J. W. MacGregor, Portage; Mrs. W. T. Clark, Janesville; and Mrs. R. G. Arveson, Frederic.

Archives and History

By MRS. C. A. HARPER
Madison

ALTHOUGH the Woman's Auxiliary is little more than ten years old, it is affiliated with an organization which was granted its charter by the Territorial Legislature in 1841. This thought immediately brings to our minds the question of what part the medical profession played in the early days of Wisconsin, and to me one of the most fascinating projects of the Auxiliary in the last few years has been research in the field of medical history, with subsequent submission of collected historical material concerning pioneer physicians to the Wisconsin State Historical Society. This task, which will culminate with the celebration of the centennial of the State Medical Society of Wisconsin in 1941, has meant many painstaking hours of work to the county and state historians. However, to those who are interested in this type of work it has also been a fascinating and absorbing task, gratifying in its results because the field is so rich. It seems to me that the most interesting periods in the life of an individual or the development of a country are those of struggle and hardship, and the picturesque lives of our pioneer physicians have left their imprint on the colorful historical background of Wisconsin.

It is with a feeling of pride that I report such excellent work by county historians and their committees that this year we have compiled 655 biographical sketches of pioneer physicians, 300 of which have already been filed with the State Historical Society. I wish to make special mention of Waukesha County which has completed its work in this field, compiling a total of 355 sketches, which have been exhibited at various medical meetings. In addition to this biographical material, which in most cases is illustrated with interesting photographs, about a hundred items such as old medicine chests, operating kits, medical books, saddles, saddle bags, articles of clothing, early records of medical societies, and letters of historical interest have been presented to the Historical Museum. I feel that this effort of the Woman's Auxiliary is of inestimable value in maintaining a record of the early days of Wisconsin, and that the members may be justly proud of their contributions. The State Historical Society has acknowledged this material with thanks, and I in turn wish to express my commendation of the county historians who have so ably assisted in this work.

In March I received from Mrs. J. J. Ryan, national historian, a long letter asking for a report of the Wisconsin Auxiliary since its inception. The following is an excerpt from this letter: "At the board meeting of the

Auxiliary to the American Medical Association, it was decided to have compiled and printed a history of the Auxiliary from its organization in St. Louis in 1922 through June, 1940. . . . As historian of your State Auxiliary will you prepare two histories—one of the year's work and one of your State from its organization—for the latter have each county president or historian write the history of her county organization from its beginning, and you in turn condense it into a readable whole."

In preparation for the compilation of this report for Mrs. Ryan I sent a request for historical material to each of the county historians. These reports of the work of each county auxiliary and a brief resume of the organization of the Woman's Auxiliary in this State have been submitted to Mrs. Ryan for inclusion in a history of the Woman's Auxiliary to the American Medical Association.

For a number of years the state historians in Wisconsin have kept scrap books, and there are now five of these large books containing clippings of all activities. These books record the accomplishments of the Woman's Auxiliary since its inception in 1929 and its growth to include twenty-seven county organizations with a membership of over eleven hundred.

In Mrs. Ryan's letter she made the request, "before preparing the state history, read and evaluate the material in the state archives—from the minutes, programs, journals, and private files," and in checking our scrap books I think it is of significance to note the wide variety of activities in which the Woman's Auxiliary is, and has been, interested besides the collection of historical material which I have described. Although it is impossible to enumerate all projects participated in by the Auxiliary, I will list those which seemed to recur most frequently in the reports as I checked them:

1. Disseminating information on medical subjects. One of the many ways in which this is carried out is through the placing of "Hygeia" in offices, schools, beauty parlors, and libraries. Oftentimes the money for this purpose is raised by some benefit function.
2. Sponsoring talks on sickness care and related subjects by representatives of the medical profession.
3. Developing social contacts among the wives of physicians as well as among members of the medical profession. In some communities, notably the smaller groups in the northern part of the State, the members of the Auxiliary meet with the physicians for a social gathering, later each group having its own business session.
4. Maintaining a loan closet for the use of the county nurses.
5. Contributing both time and money to charitable organizations, hospitals, churches, and scout troops.
6. Assisting public officers such as probation officers and contributing toys, flowers and scrap books to hospital patients, as well as necessities such as food and clothing for charitable purposes.

In submitting this report as state historian I feel that the objects of the Woman's Auxiliary as set forth in the constitution under Article 2 have been fulfilled, and that the projects undertaken and completed represent splendid accomplishments for our organization.

Remember the Annual Convention in Milwaukee in September

Headquarters: Schroeder Hotel

Mrs. Eben J. Carey, Chairman

Report of the Treasurer

By MRS. E. P. BICKLER
Milwaukee

AT THIS time of the year most people are planning their vacations. This is as it should be. But to the members of the auxiliary this time of the year means other planning as well, for in two short months we will be having our state convention when we greet our new officers and turn over our files and records to them. Last year when the state treasurer, Mrs. A. J. McCarey, transferred her records to me she could have taken a trip to Europe and I could have carried on without any difficulty. Her records were in such fine shape that anyone could have continued the work, and for me it was a pleasure.

Since the state treasurer works with the county treasurers a whole year but meets few of them, she finds herself drawing on her imagination for a mental picture of each. All year long the thought of the importance of the county treasurers has been with me, and I have wondered just why it is that they are not at the mid-winter meeting of the Board of Directors.

I have found myself wishing that I could meet the county treasurers, and as my first suggestion I recommend that they be invited to join the members of the Board of Directors at their mid-winter meeting. This would afford the state treasurer the opportunity of meeting her fellow workers, which would be of value in the work which she is doing.

My second suggestion is that each county treasurer give her successor the name and address of the state treasurer, so that she may communicate with the state treasurer stating that she has just assumed the duties of county treasurer, — a sort of get-acquainted letter. Then when it is time for the state treasurer to send out instructions for the year they are sure to reach the person for whom they are intended.

It is supposed that each county treasurer has her own files, one for the dues cards and one for the records. Without these, keeping accurate records is a hardship for the incoming officer. To me, such a record is a historical picture started by the first officer and added to by her successors so that it may be referred to for any information one may desire concerning the organization since its beginning.

The supplies county treasurers should receive from the state treasurer, which are furnished by the national auxiliary, have been forwarded to them. Any of these that have not been used may be passed on to succeeding county treasurers.

In conclusion, may I say that this has been a fine year; the reports have come in on time and have been complete. I have enjoyed every minute of my year as treasurer, and wish to thank all the county treasurers for the excellent cooperation they have given me.

Fond du Lac

Mrs. A. M. Hutter of Fond du Lac was elected president of the Woman's Auxiliary to the Fond du Lac County Medical Society at the final spring luncheon meeting on May 23 at the home of Mrs. S. E. Gavin of Fond du Lac. Mrs. H. E. Twohig is the retiring president. Other officers are: Mrs. W. C. Finn, president-elect; Mrs. J. E. Twohig, secretary, and Mrs. L. J. Keenan, treasurer, all of Fond du Lac.

During the business session an appropriation was voted for the Girl Scout troop sponsored by the auxiliary, and plans were made to send several girls to summer camp. Money was donated to the Red Cross emergency fund.

Luncheon was served at tables decorated with spring flowers. Mrs. F. W. Pope of Racine, state president, an honored guest at the meeting, addressed the group discussing activities of the organization. Mrs. Twohig, the retiring president, and Mrs. Pope were given corsage bouquets.

The hostess committee consisted of Mrs. Gavin, chairman, Mrs. P. G. McCabe, Mrs. D. N. Walters, Mrs. J. C. Yockey, and Mrs. C. P. Reslock, all of Fond du Lac.

Outagamie

Experiments in prepaid medical care in Douglas, Milwaukee, and Rock counties were outlined by Mr. G. B. Larson, assistant secretary of the State Med-

ical Society of Wisconsin, in a lecture sponsored by the Woman's Auxiliary to the Outagamie County Medical Society on May 27 at the Masonic Temple, Appleton. Over 300 women, representing the medical auxiliaries of Outagamie, Winnebago, and Brown counties, as well as a large number of Appleton women's organizations, were present.

"In an effort to find out if there is a new economic structure for medical care that will not sacrifice the excellent health gains which have made Wisconsin one of the three leading states in the United States in health accomplishments, the State Medical Society," Mr. Larson said, "has been watching trial plans in sickness insurance in three counties. The results of these plans will be reported at the meeting of the House of Delegates in September."

The speaker was introduced by Mrs. W. S. Marshall, president of the Woman's Auxiliary to the Outagamie County Medical Society. Tea was served following the program, and those assisting at the tables were Mesdames G. W. Carlson, E. L. Bolton, W. S. Giffin, E. N. Krueger, A. J. Gloss, L. B. McBain, D. M. Gallaher, J. L. Benton, E. F. McGrath, and R. T. McCarty, all of Appleton, and Mesdames G. J. Flanagan of Kaukauna, J. J. Laird of Blackcreek, and D. W. Curtin of Little Chute.

Portage

Mrs. T. L. Harrington, president of the Portage County Woman's Auxiliary, reported that Mrs. F. A. Marrs of Stevens Point, an auxiliary member, was in charge of local arrangements at the orthopedic clinic held in Stevens Point on May 18. Two hundred handicapped persons, from infants to young men and women of twenty-one, were examined, the clinic being held under the joint auspices of the Portage County Medical Society and the Crippled Children Division of the State Department of Public Instruction. Mrs. W. F. Cowan of Stevens Point, another auxiliary member, was in charge of the noon luncheon; 370 persons were served although an attendance of only 125 had been anticipated.

Rock

In celebration of the tenth anniversary of the Woman's Auxiliary to the Rock County Medical Society, a dinner was served at 6:30 p.m. at the Woman's Club in Janesville on May 28. Informal talks on the past history and future aims of the auxiliary were given by Mrs. C. N. Neupert of Madison, Dr. Jessie Allen of Beloit, Mrs. F. W. Pope of Racine, state president, and Mrs. C. A. Harper of Madison, present chairman of archives and a past-president of the state organization. Mrs. Neupert, first president of the Rock county auxiliary, and Dr. Allen, its organizer, cut the two birthday cakes.

A group of vocal solos was contributed by Mrs. F. M. Frechette, with Mrs. T. O. Nuzum playing the accompaniment. Twenty-four members and guests attended. The local program chairman, Mrs. G. S. Metcalf arranged the meeting.

Sauk

At a luncheon meeting held on Tuesday, May 28, at the Farm Kitchen near Baraboo, there was organized a Woman's Auxiliary to the Sauk County Medical Society. There were eleven wives of physicians present, representing Sauk City, Prairie du Sac, Reedsburg, and Baraboo. Mrs. E. S. Schmidt of Green Bay, chairman of organization in the Woman's Auxiliary to the State Medical Society, was present to assist with the formation of the group.

The following officers were elected:

President—Mrs. C. B. Pope, Baraboo
President-elect—Mrs. H. A. Bachhuber, Prairie du Sac
Secretary-Treasurer—Mrs. E. V. Stadel, Reedsburg

Sheboygan

Mrs. A. J. Brickbauer of Plymouth was elected president of the Woman's Auxiliary to the Sheboygan County Medical Society at the annual meeting held on June 5 at the home of Mrs. I. M. Bemis at Batavia.

Other officers selected were: Mrs. H. J. Hanson, Sheboygan Falls, president-elect; Mrs. T. J. Gunther, Sheboygan, vice-president, and Mrs. C. M. Yoran, Plymouth, secretary and treasurer.

Washington—Ozaukee

Mesdames M. E. Monroe, J. G. Hoffmann, F. W. Lehmann, and E. T. Monroe of Hartford acted as hostesses to sixteen members of the Woman's Auxiliary to the Washington–Ozaukee County Medical Society, at a luncheon in May. A business session was conducted and cards played. Plans were laid for a joint picnic of the members of the auxiliary with the members of the Washington–Ozaukee County Medical Society to be held this summer.

Winnebago

The members of the Woman's Auxiliary to the Winnebago County Medical Society took a trip to Saukville on May 27 to see the art exhibit of Dr. G. A. Hensel, pastor of St. Peter's Evangelical Lutheran Church. Dr. Hensel, who is a world traveler, has many of his excellent paintings displayed on the walls of his home.

The twenty members in the group then had a noon luncheon at the Beacon Tearoom at West Bend. In the afternoon they were taken through the aluminum plant where the many complicated processes of aluminum ware manufacture were explained in detail by members of the company. The tour was educational and interesting and the women enjoyed the demonstrations of the many uses for aluminum ware as displayed in the company's modern kitchen.

Guests on the trip were Mr. and Mrs. Emil Werner of Duncan, Oklahoma, guests at the Dr. E. B. Pfefferkorn home, and Miss Marguerite Senn. There was a short business meeting, at which plans for the June meeting were discussed. Mrs. R. H. Bitter, president, presided.

Society Proceedings

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society met on May 29 at the Beaumont Hotel in Green Bay. Dr. Anton J. Carlson, professor of physiology at the University of Chicago was the guest speaker of the evening.

A "headliner" program was presented at the society's final meeting before the summer recess, held in St. Mary's Hospital, Green Bay, June 11. The feature attraction was Dr. Sumner Koch of Northwestern University, Chicago, who presented both an afternoon clinic and an evening lecture on injuries, infections and deformities of the hand. Dinner was served to the group at 6:45 p. m. Thirty-two attended.

Chippewa

The Chippewa County Medical Society met at the Hotel Northern in Chippewa Falls, May 21. Following a 6:30 p. m. dinner a scientific program was presented, Dr. E. R. Krumbiegel, Milwaukee, and Dr. E. Evans, Minneapolis, being the guest speakers. Dr. Krumbiegel discussed "Acute Communicable Diseases; Their Diagnosis and Treatment," and Dr. Evans "Common Sense in the Treatment of Fractures."

At the meeting the society voted to have an exhibition booth at the district fair this summer. Thirty physicians attended.

Columbia—Marquette—Adams

The Columbia–Marquette–Adams County Medical Society met at the Swan Lake Country Club, Portage, May 28. Mr. J. G. Crownhart, secretary of the State Medical Society, discussed "Medical Economics." Dr. Ralph P. Sproule, president-elect of the State Society, was a guest. Eighteen were present.

Dane

The Dane County Medical Society met on June 25 at Mendota State Hospital near Madison. Four base ball teams, composed of medical staff members of Madison General Hospital, St. Mary's Hospital, Methodist Hospital and Wisconsin General Hospital provided entertainment for the group. Dinner was served at the Mendota Hospital at 7:30 p.m., after which a business meeting was held.

Dodge

The Dodge County Medical Society met June 27 at the Fond du Lac County Park, northwest of Waupun. The doctors enjoyed an afternoon of golf and a picnic supper.

Eau Claire—Dunn—Pepin

The Eau Claire–Dunn–Pepin County Medical Society met on May 27 at the Hotel Eau Claire, Eau Claire, for a dinner meeting. Dr. Theodore L. Squier, Milwaukee, was the guest speaker. His subject was "General Considerations of Allergy." Forty-six attended the meeting.

Fond du Lac

The Fond du Lac County Medical Society met on May 28 at the Hotel Retlaw in Fond du Lac for a 6:30 p. m. dinner and scientific program. Dr. F. W. Madison, Milwaukee, was the guest speaker. His subject was "Arthritis."

The society is cooperating with local health and school groups in a summer health roundup of preschool children.

Green Lake—Waushara

The Green Lake–Waushara County Medical Society met on June 4 at the Berlin Memorial Hospital. Guest speaker at the meeting was Dr. H. W. Wirka, Madison, who discussed "Fractures of the Elbow." Seventeen physicians from the two counties attended the meeting.

Jefferson

The Jefferson County Medical Society held a business meeting in Lakemills on May 16. Seventeen members attended.

On June 20 the society met at Meadow Springs Golf Club, Jefferson. Dr. H. L. Greene, Madison, spoke on "Epiphyseal Injuries of Children," illustrating his talk with lantern slides. Twenty-two were present.

La Crosse

Seventy-five physicians attended the meeting of the La Crosse County Medical Society, held at the Grandview Hospital, La Crosse, May 14. Dr. Paul C. Bucy of the University of Chicago, gave two interesting talks, one on "Common Infections Following Swimming," and another on "Early Signs and Symptoms of Brain Tumor." Both talks were illustrated by lantern slides.

Dr. Ralph P. Sproule, president-elect of the State Medical Society, attended the meeting as a guest and gave a brief address. A motion picture film was also shown illustrating the use of sodium pentothal as an anesthetic.

Milwaukee

The Milwaukee County Medical Society held its 13th annual golf tournament at the Tuckaway Country Club, June 27. Dr. A. J. Ruppenthal and Dr. A. I. Rosenberger, chairman and vice-chairman of

the golf committee, were in charge of arrangements for the tournament.

The society recently pledged its continued cooperation with the Milwaukee public health department "to see that the excellent record made by Dr. John P. Koehler as health commissioner is continued."

Pierce—St. Croix

The Pierce–St. Croix County Medical Society assisted the Crippled Children Division of the State Department of Public Instruction with the presentation of an orthopedic field clinic in River Falls on June 12.

Portage

The Portage County Medical Society held its last meeting of the season on June 12 in Stevens Point. The meeting opened at 8:15 with a series of talks on "What Is New in Pediatrics?" by Dr. J. F. Dorsch, Amherst; Dr. F. R. Krembs, Stevens Point; and Dr. H. P. Benn, Stevens Point. Dr. R. J. Stollenwerk of Stevens Point opened the general discussion which followed the talks.

Racine

Burlington members of the Racine County Medical Society were hosts of the society at a banquet at Waterford Woods on May 16. Several physicians from Kenosha and Walworth counties were also present as guests.

Speakers of the evening were Dr. R. B. Malcolm, associate professor of surgery, University of Illinois, Chicago, and Dr. Millard Tufts, Milwaukee.

Rock

Members of the Rock County Medical Society were dinner guests of the Pinehurst Sanatorium staff on May 28. Guest speakers on the scientific program which followed were Dr. R. H. Stiehm, Madison, who spoke on "Subclinical Pulmonary Tuberculosis," and Dr. W. H. Oatway, Jr., Madison, who discussed "Modern Collapse Therapy of Pulmonary Tuberculosis." Forty-five attended.

At the June meeting members of the society enjoyed an afternoon of golf at the Beloit Country Club, north of Beloit, and an evening dinner with members of the society's woman's auxiliary. Dr. Adrien Verbrugghen, Chicago, was the guest speaker at this meeting. He discussed "Treatment of Spinal Injuries."

Sheboygan

The Sheboygan County Medical Society met at St. Nicholas Hospital, Sheboygan, on June 6. Dr. David Cleveland, Milwaukee, was the guest speaker. His topic was "Head and Back Injuries."

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met in Black River Falls on June 20 for dinner and a scientific session. Dr. L. M. Morse, district health officer, gave a report on the tuberculin testing program in Wisconsin and Dr. H. M. Coon, medical director of Wisconsin State Sanatorium, Statesan, spoke on "X-ray Diagnosis of Tuberculosis." Twelve attended the meeting.

Walworth

The Walworth County Medical Society met on May 8 with members of the Walworth County Hospital staff in Elkhorn. The guest speaker was Dr. W. H. MacDonald of Lake Geneva. He discussed "Medical Ethics."

Washington—Ozaukee

The Washington–Ozaukee County Medical Society held its May meeting at St. Joseph's Hospital, Hartford, on the evening of May 29. Dr. Walter Brussock, Milwaukee, was the guest speaker on the scientific program, discussing "Treatment of Heart Disease in General Practice."

Wood

The Wood County Medical Society met in Marshfield on May 13. Dinner was served at 6:30 at the Hotel Charles and a scientific session presented at St. Joseph's Hospital. Dr. John A. Schindler, Monroe, spoke on "Clinical Interpretation of Laboratory Procedures," and a report on hospital insurance was given. Dr. Ralph P. Sproule, Milwaukee, president-elect of the State Medical Society, was a guest at the meeting. Seventeen physicians attended.

COUNTY SOCIETIES WITH 100% MEMBERSHIP

• The following county medical societies have paid dues for the current year in full as of June 25, 1940:

ASHLAND–BAYFIELD–IRON
CALUMET
CRAWFORD
GRANT
GREEN
JEFFERSON
JUNEAU
LANGLADE
LINCOLN
MANITOWOC
MARATHON
MARINETTE–FLORENCE
MONROE
OCONTO
ONEIDA–VILAS
PIERCE–ST. CROIX
PRICE–TAYLOR
RUSK
SHAWANO
WOOD

News Items and Personals

In an amendment to its articles of incorporation, certified by its president, Joseph G. Norby, Milwaukee, *Associated Hospital Service, Inc.*, announced in June that in the future its directors will consist of a maximum of twenty-one, thirteen of whom at all times will be from Milwaukee. The other possible eight directors will each represent congressional districts in the state outside of Milwaukee county, provided each has a participating hospital therein.

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At the meeting of the State Board of Medical Examiners, held in Milwaukee late in June, *Dr. H. H. Christofferson*, Colby, was elected president of the board and *Dr. Harold W. Shutter*, Wauwatosa, was named secretary.

M. L. Sanfelippo, Racine osteopath, was appointed by Governor Heil late in June to serve the remainder of the osteopathic appointment to the Wisconsin State Board of Medical Examiners, expiring on July 1, 1941, and previously held by E. C. Murphy, Eau Claire osteopath.

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Dr. A. P. Zlatnik, Two Rivers, addressed a group of Two Rivers barbers recently on the importance of sanitation in their work in the prevention of the spread of scalp and skin diseases. The talk was one of a series on the scientific aspects of barbering sponsored by the State Board of Vocational and Adult Education.

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Dr. Albert R. Tormey, Madison, was one of the principal speakers at the 30th annual meeting of the medical section of the American Life Convention in Colorado Springs, Colorado, June 4. He discussed "Osteomyelitis."

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Dr. Carl N. Neupert, Madison, traced the historical background of public health and the functions of the State Board of Health at a meeting of the Lions Club of Janesville, June 11.

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Dr. Theodore A. Teitgen, Manitowoc, spoke on the symptoms of cancer and the need for early treatment of the disease at a recent meeting of the Manitowoc Kiwanis Club.

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The second annual Northern Wisconsin Conference on Tuberculosis was held in Rice Lake, June 14. Program speakers included: *Drs. H. A. Sincock* and *Earl E. Carpenter*, Superior; *Dr. J. K. Shumate*, Bayfield; and *Dr. W. D. Stovall*, Madison.

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"Public Cooperation in Medical Progress" was the title of a talk given by *Dr. Eben J. Carey*, Milwaukee, at the May meeting of the Marquette Faculty Wives' Association.

Dr. J. F. Cary, son of *Dr. E. C. Cary* of Reedsville, has opened an office at 630 North Eighth Street, Sheboygan. Dr. J. F. Cary occupies the office of the late Dr. Clarence Sonnenburg.

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Dr. D. L. Dawson, Rice Lake, presented a brief survey of advances in surgery in the last twenty-five years, in a talk before the Rice Lake Kiwanis Club, May 13.

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A plaque honoring Brig. Gen. Erastus B. Wolcott, pioneer surgeon and soldier of Milwaukee, was unveiled May 27 in Columbia Hospital, Milwaukee, in an operating room remodeled with funds from the estate of Dr. Wolcott's grandson, the late Dr. John L. Yates. Speakers at the ceremony were *Drs. C. H. Stoddard* and *Stanley J. Seeger* of the hospital's staff.

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Dr. Luther E. Holmgren, Madison, was named president of the Jackson Clinic–Methodist Hospital Alumni Association at its third annual meeting in Madison, May 31 and June 1. Other officers elected were:

President-elect — Dr. Harry Vander Kamp, Baraboo
Vice-president—Dr. C. K. Schubert, Madison
Secretary-treasurer—Dr. D. L. Williams, Madison
Corresponding secretary—Dr. A. S. Jackson, Madison

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Dr. Henry H. Kleinpell, Prairie du Chien, celebrated his fortieth anniversary of medical practice the first week in June by attending clinics and meetings at Rush Medical College, Chicago, his alma mater.

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About 200 persons attended festivities at Lake View Sanatorium, Madison, commemorating the tenth anniversary of the institution. *Dr. W. C. Reineking*, superintendent of Lake View, presented certificates to seven employes who have worked there for ten years. Movies of life in the sanatorium were shown, talks were given by members of its staff and a barbecue lunch was served in the grove near the sanatorium.

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At the annual convention of the American College of Chest Physicians in New York City, *Dr. A. L. Banyai*, at the expiration of his term as governor of the College for the state of Wisconsin, was elected regent of the College's regional district No. 9. He presented a paper in the medical section of the convention on "Newer Aspects of Pneumoperitoneum Treatment of Pulmonary Tuberculosis."

The *University of Wisconsin Medical School* observed its Alumni Day, May 23, in Madison. The first part of the morning program was as follows:

1. *Colored Slides of Common and Rare Skin Lesions*—
   Dr. G. A. Cooper, research associate in dermatology.
2. *Experimental Studies of the New Anesthetic, Vinylether*—
   Dr. O. S. Orth, instructor in physiology.
3. *Present Status of Desoxycorticosterone Therapy*—
   Dr. E. S. Gordon, instructor in physiologic chemistry and research associate in medicine.
4. *Vitamin Deficiency in Pregnancy*—
   Dr. C. J. Lund, fellow in obstetrics.
5. *Prevention of Recurrent Abortion*—
   Drs. E. L. Sevringhaus, professor of medicine, and R. E. Campbell, associate professor of obstetrics and gynecology.
6. *Experimental Peritonitis*—
   Dr. A. R. Curreri, instructor and senior resident in surgery.
7. *The Use of Vitallium in Bone Surgery*—
   Dr. R. E. Burns, professor of orthopedic surgery.
8. *The Effect of Gelatin on Muscular Performance*—
   Dr. F. A. Hellebrandt, associate professor of physiology.

Twenty-five demonstrations of work now being carried on at the University were presented after these lectures. Luncheon was served at 1 p.m. and at 2 p.m. *Dr. W. S. Middleton,* dean of the medical school, spoke on "Some Rationalized Therapeutic Experiences."

At 3 p.m. Dr. George Curtis of the department of research surgery, Ohio State University, talked on "Rationale of Splenectomy in the Treatment of Certain Anemias." After Dr. Curtis' presentation, *Drs. E. A. Pohle* and *H. P. Rusch* conducted tours through the new McArdle Memorial Laboratory. In the evening a banquet was given for the group at the Park Hotel, Madison, by the class of 1930.

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Dr. Hans Reese of the department of neurology, University of Wisconsin Medical School, was elected president of the Milwaukee Neuropsychiatric Society at its meeting in Milwaukee, May 28. *Drs. Saul Pollack* and *Gilbert Rich,* Milwaukee, were reelected vice-president and secretary-treasurer, respectively.

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Dr. E. L. Sevringhaus, Madison, took office as president of the Society for the Study of Internal Secretions, at a formal banquet June 10 at the Hotel Roosevelt, New York City.

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Dr. James A. Evans, La Crosse, has accepted a position on the staff of the Lahey Clinic, Boston. Dr. Evans is well known to Wisconsin physicians both for his professional attainments and his contributions to organized medicine. As a member of the Council on Scientific Work of the State Medical Society in recent years, Dr. Evans has given definite and substantial aid in arranging annual meeting programs, scientific exhibits and graduate clinics.

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Dr. George M. Curtis of Ohio State University was the guest speaker on the Students' Day program at the *University of Wisconsin Medical School,* May 24, sponsored by Sigma Sigma. His subject was "Iodine—in Fact and Fancy."

Coming Events

Examination for Appointment as Commissioned Officers in the Medical Corps of the U. S. Navy.—The next examination for doctors of medicine desiring to enter the Medical Corps of the United States Navy will be held on August 19, 1940, at the following hospitals:

U. S. Naval Hospital, Chelsea, Massachusetts.
U. S. Naval Hospital, Brooklyn, New York.
Norfolk Naval Hospital, Portsmouth, Virginia.
U. S. Naval Hospital, Pensacola, Florida.
U. S. Naval Hospital, San Diego, California.
Naval Medical Center, Washington, D. C.
U. S. Naval Hospital, Newport, Rhode Island.
U. S. Naval Hospital, Philadelphia, Pennsylvania.
U. S. Naval Hospital, Charleston, South Carolina.
U. S. Naval Hospital, Great Lakes, Illinois.
U. S. Naval Hospital, Mare Island, California.
U. S. Naval Hospital, Puget Sound, Bremerton, Washington.

Graduates of Class "A" medical schools who have had an internship in a civilian hospital and who are physically and professionally qualified may be commissioned in the permanent Medical Corps of the Navy as Assistant Surgeons with the rank of Lieutenant (junior grade). Applicants must be less than thirty-two (32) years of age at the time they receive their commissions, citizens of the United States, physically qualified for appointment as officers in the Medical Corps and must demonstrate their professional qualifications by competitive written, oral and practical examinations. The professional examination will embrace the subjects of: (1) general medicine, (2) general surgery, (3) obstetrics and gynecology, and (4) preventive medicine and medical jurisprudence.

The pay and allowances for Assistant Surgeons with the rank of Lieutenant (junior grade) in the Medical Corps of the Navy is $2,699 per year if

the officer has no dependents, and $3,158 per year if he has dependents.

Additional information regarding physical requirements, etc., may be obtained by addressing a letter to the Bureau of Medicine and Surgery, Navy Department, Washington, D. C. Applications must be completed and received in the Bureau of Medicine and Surgery prior to August 1, 1940, in order that authorization may reach the applicant in sufficient time for him to appear for examination on August 19, 1940.

Annual Meeting of Eye and Ear Specialists.—The American Academy of Ophthalmology and Otolaryngology will hold its forty-fifth annual convention in Cleveland, October 6 to 11, with headquarters at the Hotel Cleveland.

The Academy, an organization of more than 2,500 specialists in diseases of the eye, ear, nose and throat, carries on an active program of education for its members. In addition to scientific papers, an elaborate series of courses is presented at each convention to bring the members up to date in their chosen fields. More than 100 of these teaching lectures will be offered this year.

In the past year arrangements have been made to extend the teaching activities to young physicians just entering on specialization. Home study courses are being prepared for any of these young men who wish to take them and their work will be supervised by members of the academy interested in improving the caliber of specialists in practice.

The Cleveland meeting will be noteworthy in several respects.

The Academy will honor Dr. Secord H. Large, Cleveland, who this year completes thirty years as comptroller of the organization. Dr. Large as the honor guest of the meeting will receive many special distinctions.

Immediately following the Academy meeting, there will be a Pan-American Congress of Ophthalmology, October 11 and 12, which eye specialists from all the Latin American countries are expected to attend.

Dr. Frank Brawley, Chicago, is president of the Academy and Dr. Frank R. Spencer, Boulder, Colo., is president-elect. Vice presidents are Drs. Arthur W. Proetz, St. Louis; Joseph F. Duane, Peoria, Ill., and Charles T. Porter, Boston. Dr. William P. Wherry, 1500 Medical Arts Building, Omaha, is executive secretary.

American Congress of Physical Therapy.—The 19th annual scientific and clinical session of the American Congress of Physical Therapy will be held September 2, 3, 4, 5, and 6, 1940, at the Hotel Statler, Cleveland, Ohio.

For information concerning the seminar and preliminary program of the convention proper, address American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

BIRTHS

A son to Dr. and Mrs. Milton Trautmann, Madison, May 27.

A daughter, Joan Barbara, to Dr. and Mrs. C. O. Diamond, Milwaukee, May 21.

A son to Dr. and Mrs. E. C. Bach, Milwaukee, June 15.

A son, Hugh John, to Dr. and Mrs. Rolf A. Quisling, Madison, June 15.

A daughter to Dr. and Mrs. H. J. Dvorak, Milwaukee, June 13.

A son, Charles Richard, to Dr. and Mrs. R. C. Warner, Milwaukee, June 17.

MARRIAGES

Dr. Joseph Steckbauer, Manitowoc, and Miss Frances Zendala, Manitowoc, on May 25.

Dr. Conde F. Conroy, Milwaukee, to Miss Margaret Murphy, Milwaukee, on June 8.

Dr. George Reay, Onalaska, to Miss Francis Robb Wise, Hayward, on June 8.

Dr. Sverre Quisling, Madison, to Miss Virginia Constance Moe, Goodman, June 8.

DEATHS

Dr. C. H. Beadles, Kenosha, died June 8. The doctor, who was 53 years of age, was industrial surgeon for the Nash–Kelvinator Corporation in Kenosha at the time of his death. Previously he had served in a similar capacity for Fairbanks, Morse and Company, Beloit, and Nash Motors, Racine.

Dr. Beadles was graduated from Creighton University School of Medicine, Omaha, in 1915. He was first lieutenant in the medical corps in France during the World War and in 1920 returned to Europe for two years of service with the American Red Cross.

Dr. Beadles is survived by his widow, a daughter and a son.

Dr. John Thomas Corr, Racine, died June 5 in a Racine hospital. He was 70 years of age.

A native of Ireland, Dr. Corr came to the United States in 1885. He attended Rush Medical College in Chicago, being graduated in 1896. Later he took special training in the treatment of diseases of the eye, ear, nose and throat, and limited his thirty years of medical practice in Racine to the treatment of these diseases.

Dr. Corr was a World War veteran. He was a member of the Racine County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Surviving him are his widow and one son.

Dr. Sanford W. Forbush, Beloit, died on May 18 of a heart ailment, after an illness of a few weeks.

The doctor was born in 1883. He was graduated from Northwestern University Medical School, Chicago, in 1907, and began his Wisconsin medical practice in Orfordville. In 1924, after engaging in

postgraduate study in New York City, he moved to Beloit where he specialized in the treatment of diseases of the eye, ear, nose and throat until his last illness.

Dr. Forbush was a member of the Rock County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow and three sons.

Dr. Guy W. Henika, Madison, was killed in an automobile accident near Arlington, Wisconsin, June 8. His death ended a career of twenty-seven years in state public health work. At the time of the fatal accident he was deputy state health officer for nine counties in southwestern Wisconsin.

Dr. Henika was born February 14, 1871, in Wayland, Michigan. He was graduated from Harvey Medical College, Chicago, in 1897, and was awarded a master's degree in public health by the University of Wisconsin in 1912.

After many years of private practice in Readstown and a brief period of practice in Beaver Dam, Dr. Henika was appointed a deputy state health officer in 1913. For eight years, beginning in 1928, he served as assistant state health officer.

Dr. Henika was a member of the Dane County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow, a son and a daughter.

SOCIETY RECORDS

New Members

D. H. Lando, 3075 North Thirty-fifth Street, Milwaukee.

C. M. Ihle, Eau Claire.

P. B. Theobald, Oconomowoc.

J. F. Klepfer, Waupun.

A. C. Edwards, State Board of Health, Madison.

J. J. Sazama, Bloomer.

F. S. Tuffley, Boscobel.

Frances H. Grimstad, 1 South Pinckney Street, Madison.

D. W. McCormick, 2609 University Avenue, Madison.

Leonard Long, 1300 University Avenue, Madison.

Changes in Address

A. L. Reinardy, Stevens Point, to 633 Washington Street, Burlington.

A. H. Hermann, West Allis, to 3107 West National Avenue, Milwaukee.

C. V. Bachelle, Chicago, Illinois, to Delavan Lake, Wisconsin.

H. M. Levin, Milwaukee, to Darien.

CORRESPONDENCE

"A REVELATION"

Drs. Cole & Watson
317 Watson St.
Ripon, Wisconsin

June 10, 1940.

Wisconsin Medical Journal,
917 Tenney Bldg.,
Madison, Wis.

Dear Sirs: It was a revelation to read "Give the Patient a Break" in the May issue. The author bespeaks my sentiments and I feel those of many other men who read Cabot's article in the April issue of American.

It would be a fine thing to let the American Magazine hear of the reaction to the article.

Sincerely,
Drs. Cole & Watson,
(Signed) David F. Cole, M.D.

TECHNICAL EXHIBITORS, 1940 ANNUAL MEETING

Space allotted in the main arena of the Milwaukee Auditorium for technical exhibits at the 1940 annual meeting of the State Medical Society is materially greater than that allotted in 1939. Nevertheless, all available space has been reserved. Firms who have reserved exhibit space for the coming meeting are:

A. S. Aloe Company
Bard–Parker Company, Inc.
Borden Company
S. H. Camp & Company
Carnation Company
Casper's Foto Shop
CIBA Pharmaceutical Products, Inc.
Coca-Cola Company
Duke Laboratories, Inc.
Eli Lilly & Company
H. G. Fischer & Company
General Electric X-Ray Corporation
Gerber Products Company
Hanovia Chemical & Manufacturing Company
H. J. Heinz Company
Horlick's Malted Milk Corporation
Hurley X-Ray Company
E. H. Karrer Company
Kelley–Koett Manufacturing Company, Inc.
Kremers–Urban Company
Lakeside Laboratories, Inc.
Lederle Laboratories, Inc.
J. B. Lippincott Company
M & R Dietetic Laboratories, Inc.
Mead Johnson & Company
Medical Protective Company
Mellin's Food Company
Mennen Company
C. V. Mosby Company
V. Mueller & Company
Arthur H. Neumann, Inc.
Parke, Davis & Company
Pet Milk Sales Corporation
Petrolagar Laboratories
Philip Morris & Company
Photoart House
Physicians & Hospitals Supply Company, Inc.
Roemer Drug Company
W. B. Saunders Company
Scanlan–Morris Company
Sharp & Dohme
Smith, Kline & French Laboratories
E. R. Squibb & Sons
United States Hospital Supply Company
United States Standard Products Company
Westinghouse X-Ray Company, Inc.
White Laboratories, Inc.
Winthrop Chemical Company, Inc.
Zimmer Manufacturing Co.

Ten Graduate Centers on Chest Diseases Announced for August

IN AFTERNOON and evening programs, under the joint sponsorship of the Wisconsin Anti-Tuberculosis Association, the committee on chest diseases of the State Medical Society, the State Board of Health and Wisconsin sanatoria, ten one-day institutes on chest diseases are to be held in the state, August 5–9 and August 12–16. Following is a condensed schedule of the meetings:

Monday, August 5, Sunnyview Sanatorium, Winnebago
Tuesday, August 6, Rockyknoll Sanatorium, Plymouth
Wednesday, August 7, Maple Crest Sanatorium, Whitelaw
Thursday, August 8, Hickory Grove Sanatorium, West DePere
Friday, August 9, Mount View Sanatorium, Wausau

Monday, August 12, Pureair Sanatorium, Bayfield
Tuesday, August 13, Mount Washington Sanatorium, Eau Claire
Wednesday, August 14, Oak Forest Sanatorium, Onalaska
Thursday, August 15, Pinehurst Sanatorium, Janesville
Friday, August 16, Sunnyrest Sanatorium, Racine

The institutes are made possible by a fund left to the Wisconsin Anti-Tuberculosis Association by the late Dr. Hoyt E. Dearholt, executive secretary of the Association, and former councilor and president of the State Medical Society. Speakers will include:

J. A. Carswell, M.D., D.P.H., formerly director of the Division of Communicable Disease Control of the Alaska Territorial Department of Health; now associate executive secretary W.A.T.A.

H. H. Christensen, M.D., attending thoracic surgeon, Mt. View Sanatorium, Wausau.

H. M. Coon, M.D., formerly superintendent, River Pines Sanatorium, Stevens Point; now superintendent of Wisconsin State Sanatorium, Wales.

F. L. Jennings, M.D., formerly medical director of Glen Lake Sanatorium, Minneapolis; now superintendent and medical director, Sunnyside Sanatorium, Indianapolis.

A. A. Pleyte, M.D., director medical department, W.A.T.A. and chairman of the State Medical Society's committee on tuberculosis and chest diseases.

J. D. Steele, M.D., formerly associated with Dr. John Alexander of the University of Michigan; now thoracic surgeon at Muirdale Sanatorium, Milwaukee.

R. H. Stiehm, M.D., formerly W.A.T.A. medical staff member; now with the student health service and associate professor of medicine at the University of Wisconsin.

The program for each center follows, and a reservation blank and further information will be found on page 575 of this issue.

PROGRAM
CHEST DISEASE INSTITUTES

(Sanatorium physician presiding)

P.M.

2:30 *Purpose of Meeting*
Dr. A. A. Pleyte, W.A.T.A., Milwaukee
or Dr. J. A. Carswell, W.A.T.A., Milwaukee

3:00 *Treatment of Empyema*
*Dr. H. H. Christensen, Wausau
or *Dr. John D. Steele, Milwaukee
Discussion
*Dr. R. H. Stiehm, Madison
or *Dr. H. M. Coon, Statesan

3:45 *Where to Find Tuberculosis*
Dr. A. A. Pleyte
Discussion
*Dr. R. H. Stiehm
or *Dr. H. M. Coon

4:15 *Diagnostic Procedures in Diseases of the Chest*
Dr. F. L. Jennings, Indianapolis
Discussion
*Dr. H. H. Christensen
or *Dr. John D. Steele

5:10 *Opportunities of the Physician in a Tuberculosis Discovery Program*
*Dr. R. H. Stiehm
or *Dr. H. M. Coon
Discussion
Sanatorium Physician

6:00 Dinner (furnished by the sanatorium)

7:30 *Modern Treatment of Tuberculosis*
Dr. F. L. Jennings
Discussion
*Dr. R. H. Stiehm
or *Dr. H. M. Coon

8:10 *Technic of Taking and How to Interpret Chest X-ray Films*
Dr. J. A. Carswell

8:25 *X-ray Film Question Box*
Physicians are urged to bring interesting and questionable films; also a brief history on each case.

8:50 *Questions on Day's Program*

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* Dr. H. H. Christensen (week of Aug. 5); Dr. H. M. Coon (week of Aug. 5).
Dr. John Steele (week of Aug. 12); Dr. R. H. Stiehm (week of Aug. 12).

Preliminary Arrangements For 99th Anniversary Meeting of State Medical Society, Milwaukee, September 18, 19 and 20, Announced; Industrial Health Featured

A THREE-DAY scientific program that will place emphasis on occupational diseases and injuries at the 99th anniversary meeting of the State Medical Society of Wisconsin, to be held in Milwaukee, September 18, 19 and 20, was announced July 1 by Dr. C. J. Smiles, Ashland, in charge of the program for the Council on Scientific Work. In a related announcement, Dean Eben J. Carey of Marquette University School of Medicine declared that a single block of exhibit space, totalling 1,700 square feet, will be devoted to exhibits within the field of industrial health, —the theme of the meeting. An additional 1,100 square feet of exhibit space will present other scientific exhibits.

Twenty-three out-of-state speakers will be interspersed in the program with close to 100 members of the State Medical Society. Out-of-state speakers will include:

A. J. Lanza, Metropolitan Life Insurance Company, New York City, New York.

Chester Keefer, director, Robert Dawson Evans Memorial Hospital, Boston, Massachusetts; associate professor of medicine, Harvard Medical School, and Wade professor of medicine, Boston University School of Medicine.

Lee Foshay, professor of bacteriology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

F. J. Hirschboeck, Duluth Clinic, Duluth, Minnesota.

E. G. Billings, assistant professor of psychiatry, University of Colorado School of Medicine, Denver, Colorado.

Arthur R. Elliott, clinical professor of medicine, Rush Medical College, University of Chicago, Chicago, Illinois.

Grover Penberthy, professor of clinical surgery, Wayne University College of Medicine, Detroit, Michigan.

Edwin F. Daily, Children's Bureau, U. S. Department of Labor, Washington, D. C.

John L. McKelvey, professor of obstetrics and gynecology, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis, Minnesota.

Charles E. Galloway, assistant professor of obstetrics and gynecology, Northwestern University Medical School, Evanston, Illinois.

Gerald M. Cline, Bloomington, Illinois.

John A. Bigler, assistant professor of pediatrics, Northwestern University Medical School, Highland Park, Illinois.

Gordon B. New, professor of otolaryngology and rhinology, University of Minnesota Graduate School, Minneapolis–Rochester; The Mayo Clinic, Rochester, Minnesota.

George E. Shambaugh, Jr., associate clinical professor of laryngology and otology, Rush Medical College, University of Chicago, Chicago, Illinois.

Peter C. Kronfeld, Chicago, Illinois.

F. Bruce Fralick, professor of ophthalmology, University of Michigan Medical School, Ann Arbor, Michigan.

Franklin G. Ebaugh, professor of psychiatry, University of Colorado School of Medicine, Denver, Colorado.

W. A. Fansler, clinical associate professor of surgery, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis, Minnesota.

Samuel H. Boyer, Jr., Duluth, Minnesota.

C. C. Higgins, Cleveland Clinic, Cleveland, Ohio.

Fred E. B. Foley, clinical associate professor of urology, University of Minnesota Medical School, and clinical associate professor of surgery, University of Minnesota Graduate School, Minneapolis, Minnesota.

James Evans, Lahey Clinic, Boston, Massachusetts.

E. L. Jenkinson, associate professor of radiology, Northwestern University Medical School, Chicago, Illinois.

Round table luncheons for limited group discussion on timely subjects will again be held on Thursday and Friday noons. Late Wednesday evening will be devoted to the usual smoker, and the annual dinner will be held on Thursday evening, September 19.

House of Delegates

The House of Delegates will hold its first meeting at 6:30 p.m. Tuesday evening, September 17, with subsequent sessions on Wednesday evening and Thursday morning.

MEMBERS—1940 HOUSE OF DELEGATES

Society	*Delegate*	*Alternate Delegate*
Ashland–Bayfield–Iron	J. W. Prentice, Ashland	C. J. Smiles, Ashland
Barron–Washburn–Sawyer–Burnett	A. S. White, Rice Lake	R. W. Adams, Chetek
Brown–Kewaunee–Door	P. R. Minahan, Green Bay	W. W. Kelly, Green Bay
	O. A. Stiennon, Green Bay	W. E. Leaper, Green Bay
Calumet	F. P. Knauf, Kiel	J. W. Goggins, Chilton
Chippewa	C. N. B. Hatleberg, Chippewa Falls	A. J. Somers, Chippewa Falls
Clark	M. C. Rosekrans, Neillsville	B. H. Dike, Owen
Columbia–Marquette–Adams	H. E. Gillette, Pardeeville	H. M. Caldwell, Columbus
Crawford	C. A. Armstrong, Prairie du Chien	E. T. Ackerman, Gays Mills
Dane	L. W. Peterson, Sun Prairie	N. A. Hill, Madison
	Louis Fauerbach, Madison	F. L. Weston, Madison
	W. D. Stovall, Madison	A. T. Smedal, Stoughton
	A. R. Tormey, Madison	S. A. McCormick, Madison
Dodge	A. G. Hough, Beaver Dam	F. T. Clark, Waupun
Douglas	T. J. O'Leary, Superior	Charles W. Giesen, Superior
Eau Claire–Dunn–Pepin	S. L. Henke, Eau Claire	B. F. Johnson, Mondovi
Fond du Lac	D. J. Twohig, Fond du Lac	J. C. Devine, Fond du Lac
Forest	G. W. Ison, Crandon	E. G. Ovitz, Laona
Grant	E. H. Spiegelberg, Boscobel	J. D. Glynn, Lancaster
Green	L. E. Creasy, Monroe	J. H. Bristow, Monroe
Green Lake–Waushara	A. A. Beck, Wautoma	L. J. Seward, Berlin
Iowa	L. S. Graves, Mineral Point	S. B. Marshall, Hollandale
Jefferson	W. S. Waite, Watertown	G. E. Eck, Lake Mills
Juneau	C. A. Vogel, Elroy	A. R. Kaufman, Mauston
Kenosha	G. C. Schulte, Kenosha	W. C. Stewart, Kenosha
La Crosse	A. H. Gundersen, La Crosse	E. E. Gallagher, La Crosse
Lafayette	(Not reported)	
Langlade	W. P. Curran, Antigo	(Not reported)
Lincoln	F. C. Lane, Merrill	R. G. Baker, Tomahawk
Manitowoc	E. C. Cary, Reedsville	T. H. Rees, Manitowoc
Marathon	J. F. Smith, Wausau	E. E. Flemming, Wausau
Marinette–Florence	J. W. Boren, Marinette	A. T. Nadeau, Marinette
Milwaukee	J. O. Dieterle, Milwaukee	B. J. Birk, Milwaukee
	C. W. Eberbach, Milwaukee	E. A. Brzezinski, Milwaukee
	Charles Fidler, Milwaukee	S. J. Darling, Milwaukee
	R. E. Galasinski, Milwaukee	G. S. Flaherty, South Milwaukee
	J. L. Garvey, Milwaukee	P. J. Niland, Milwaukee
	L. W. Hipke, Milwaukee	P. E. Oberbreckling, Milwaukee
	Irwin Schulz, Milwaukee	E. D. Schwade, Milwaukee
	L. M. Wieder, Milwaukee	C. M. Schoen, Milwaukee
	J. C. Griffith, Milwaukee	R. A. Toepfer, West Allis
	A. R. Langjahr, Milwaukee	Bernard Krueger, Cudahy
	H. O. McMahon, Milwaukee	D. F. Pierce, Hales Corners
	J. W. Smith, Milwaukee	W. J. Scollard, Milwaukee
	W. F. Grotjan, Milwaukee	S. E. Biller, Milwaukee
Monroe	A. R. Bell, Tomah	G. C. Devine, Ontario
Oconto	J. S. Dougherty, Suring	C. R. Kwapy, Oconto
Oneida–Vilas	W. S. Bump, Rhinelander	I. E. Schiek, Rhinelander
Outagamie	C. D. Neidhold, Appleton	D. M. Gallaher, Appleton
Pierce–St. Croix	A. E. McMahon, Glenwood City	O. H. Anderson, Plum City
Polk	L. O. Simenstad, Osceola	W. B. Cornwall, Amery
Portage	A. G. Dunn, Stevens Point	M. G. Rice, Stevens Point
Price–Taylor	J. D. Leahy, Park Falls	H. B. Norviel, Phillips
Racine	R. M. Kurten, Racine	T. C. Hemmingsen, Racine
Richland	W. C. Edwards, Richland Center	George Parke, Viola
Rock	W. A. Munn, Janesville	W. T. Clark, Janesville
	H. E. Kasten, Beloit	H. A. Raube, Beloit
Rusk	L. M. Lundmark, Ladysmith	W. F. O'Connor, Ladysmith
Sauk	A. C. Edwards, Baraboo	M. F. Huth, Baraboo
Shawano	A. A. Cantwell, Shawano	F. L. Litzen, Gresham
Sheboygan	C. J. Weber, Sheboygan	A. C. Radloff, Plymouth
Trempealeau–Jackson–Buffalo	R. L. Alvarez, Galesville	M. O. Bachhuber, Alma
Vernon	W. M. Trowbridge, Viroqua	W. H. Remer, Chaseburg
Walworth	E. D. Sorenson, Elkhorn	C. J. Brady, Lake Geneva
Washington–Ozaukee	J. G. Hoffmann, Hartford	O. J. Hurth, Cedarburg
Waukesha	J. C. Hassall, Oconomowoc	R. E. Davies, Waukesha
Waupaca	J. H. Murphy, Clintonville	R. K. Irvine, Manawa
Winnebago	A. G. Koehler, Oshkosh	J. P. Canavan, Neenah
Wood	K. H. Doege, Marshfield	F. X. Pomainville, Wis. Rapids

Dr. Frank H. Lahey, Boston, Named President-Elect of American Medical Association at New York Session

ONE hundred and three Wisconsin members attended the annual meeting of the American Medical Association, held in New York City, June 10-14, at which Dr. Frank H. Lahey, Boston, was named president-elect. Featured in actions of the House of Delegates of the Association were the following:

1. Naming of Wisconsin delegate, Dr. Joseph F. Smith, Wausau, to Reference Committee on Sections and Section Work.
2. Adoption of a recommendation from Michigan looking toward a coordination of experiments in the field of the so-called medical service plans, under the guidance of the Bureau of Medical Economics and the Committee on Medical Care of the American Medical Association.
3. A strong reassertion of the position of medicine that hospital service plans shall not include medical service benefits except in the form of cash, payable directly to the subscriber.
4. Reassertion of the Principles of Medical Ethics to set forth the position of medicine in the field of patents and copyrights.
5. Creation of a Committee on Medical Preparedness.
6. Election of Dr. W. F. Braasch, Rochester, Minnesota, to fill the unexpired term of the late Charles B. Wright, Minneapolis, on the Board of Trustees of the Association.

Awards to Wisconsin Physicians

Dr. Frederick A. Davis, Madison, was awarded the Herman Knapp gold medal by the section on ophthalmology of the American Medical Association for the paper he presented at the St. Louis session in 1939 on "Primary Tumors of the Optic Nerve and Their Relationship to Recklinghausen's Disease." This medal has been awarded only seven times in the last twenty-six years; Dr. Davis is the first to receive it in the last ten years.

Dr. Arnold S. Jackson, Madison, won a certificate of merit for his exhibit illustrating goiter and other diseases of the thyroid gland.

Wisconsin Attendants

Following are the names of Wisconsin physicians who attended the meeting:

Arveson, R. G. — Frederic
Babbitz, A. L. — Milwaukee
Banyai, A. L. — Wauwatosa
Bayley, W. E. — La Crosse
Belknapp, E. L. — Milwaukee
Boeckman, F. A. — Marshfield
Bowing, I. E. — Kenosha
Brindley, B. I. — Madison
Brussock, W. A. — Milwaukee
Busse, A. A. — Jefferson
Carey, E. J. — Milwaukee
Cowan, I. I. — Milwaukee
Cunningham, H. A. — Milwaukee
Curran, W. P. — Antigo
Davis, F. A. — Madison
Echols, C. M. — Milwaukee
Eisenberg, P. J. — Milwaukee
Enzer, Norbert — Milwaukee
Epstein, Ely — Milwaukee
Epstein, Stephan — Marshfield
Farnsworth, R. W. — Janesville
Foerster, O. H. — Milwaukee
Foster, R. C. — Madison
Garvey, J. L. — Milwaukee
Gavin, S. E. — Fond du Lac
Gebhard, U. E. — Milwaukee
Gregory, L. W. — Manitowoc
Greeley, H. P. — Madison
Gundersen, A. H. — La Crosse
Gundersen, Gunnar — La Crosse
Hardgrove, M. A. — Milwaukee
Hawk, M. H. — Madison
Heifetz, E. C. — Milwaukee
Hermann, A. H. — West Allis
Herner, W. L. — Milwaukee
Hertzog, A. J. — Eau Claire
Hill, N. A. — Madison
Houck, M. P. — La Crosse
Hoyme, Gjermund — Eau Claire
Irvine, R. K. — Manawa
Jackson, A. S. — Madison
Jamieson, R. D. — Racine
Jekel, J. M. — Milwaukee
Jenner, J. A. — Milwaukee
Jorgenson, H. L. — Marinette
Kearns, W. M. — Milwaukee
Kilkenny, G. S. — Milwaukee
Killins, W. A. — Green Bay
Kult, A. S. — Milwaukee
Kurtz, C. M. — Madison
Kurtz, E. C. — Milwaukee
Lademan, O. E. — Milwaukee
Lettenberger, Joseph — Milwaukee
Maloof, G. J. — Madison
Margoles, F. C. — Milwaukee
McCormick, S. A. — Madison
Miller, E. W. — Milwaukee
Milson, Louis — Green Bay
Minahan, J. J. — Chilton
Moriarty, L. J. — Two Rivers
Morton, S. A. — Milwaukee
Murphy, F. D. — Milwaukee
Pechous, C. E. — Kenosha
Pessin, S. B. — Madison
Petersen, G. W. — Neenah
Pope, F. W. — Racine
Pugh, G. J. — Milwaukee
Quisling, Sverre — Madison
Reese, H. H. — Madison
Regan, J. R. — Milwaukee
Rich, G. J. — Milwaukee
Robertson, M. J. — Bayfield
Russell, J. A. — Random Lake
Sargent, J. C. — Milwaukee
Satter, O. E. — Prairie du Chien
Sauthoff, August — Mendota
Schmidt, E. R. — Madison

Schneiders, E. F. — Madison
Schowalter, R. P. — Milwaukee
Schumacher, H. S. — Milwaukee
Schutte, A. G. — Milwaukee
Seeger, S. J. — Milwaukee
Seward, L. J. — Berlin
Sevringhaus, E. L. — Madison
Sherwood, M. W. — Milwaukee
Shutkin, M. W. — Milwaukee
Shutter, H. W. — Milwaukee
Simenson, R. S. — Valders
Sivyer, A. W. — Milwaukee
Sleyster, Rock — Wauwatosa
Smith, J. F. — Wausau
Smith, L. D. — Milwaukee
Squier, T. L. — Milwaukee
Stang, H. M. — Eau Claire
Sullivan, A. G. — Madison
Taylor, J. G. — Milwaukee
Thill, G. E. — Milwaukee
Van Hecke, L. J. — Milwaukee
Warschauer, Bruno — Milwaukee
Waters, R. M. — Madison
Wilson, O. M. — Wausau
Werrell, W. A. — Madison
Ziegler, L. H. — Wauwatosa

Are Radiologists Selfish?*

By J. E. HABBE, M. D.
Milwaukee

NOT long ago there appeared in a local daily paper an editorial sharply criticizing the radiologists of the State of Wisconsin for attempting to obstruct Associated Hospital Service in its inclusion of medical services in the nature of fifty per cent payment by Associated Hospital Service for diagnostic X-ray, laboratory service, electrocardiograms, and basal metabolism tests. It was stated rather baldly that radiologists do not wish to cooperate in spreading widely the cost of catastrophic illnesses and in giving to the low-income group the latest scientific advancements of medicine. It was indicated, also, that the radiologists had a purely selfish argument in support of their request. It was indicated further that the services referred to were "technical services." In the interests of fairmindedness it might be well to get a physician's viewpoint on the matter.

Let it be said in the very beginning that neither radiologists nor any other group of physicians has any contention with those who would spread the cost of catastrophic illness by means of sickness insurance based on sound actuarial figures; nor can it be fairly stated that radiologists are selfish in their wish to have Associated Hospital Service either not include their medical services in hospital insurance care or include them in the form of cash benefits for physicians' fees. Most radiologists in the City of Milwaukee, and probably the same statement can be made for the State of Wisconsin, have reasonably equitable financial arrangements with the hospitals in which they serve. Thus, in the present form of the subscriber contract they stand to lose nothing financially by the arrangement of the Service Corporation's paying half of the medical expense for diagnostic X-ray or laboratory services. Where, then, the basis for the statement that radiologists are selfish when they are only concerned with the patient's getting the very best of medical care not just this year but next year and indefinitely into the future?

Radiologists are concerned lest the best of medical care may be what the patients will not receive under their hospital contracts if the Hospital Service Corporation remunerates the member hospital on a straight per diem basis and makes no separate allocation of funds for these medical services which they are including together with basic bed, board, and nursing hospital service. We are not without the benefit of past experience in other hospital service corporation plans which have, for a time at least, included medical services. In Associated Hospital Service for greater New York, medical services were freely included with no separate allocation of funds for the medical attention aside from the allocation of funds for the general bed, board, and nursing care. What has been the result? There have been so many requests, some perhaps needless or at least ill-considered, for these "free" medical services for the hospitalized cases, many of whom were in as diagnostic problems and not as cases of catastrophic illness, that the medical service became a perfunctory procedure in many instances in those institutions, since there were no longer

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funds available to cover adequately the cost of the services included.

High-grade medical care is not cheap, and when funds run low the service is almost invariably cheapened. In the California West Coast Hospital Service and in the Boston Blue Cross Hospital Service similar situations have developed whereby it was considered necessary to remove completely the X-ray benefits, previously included along with basic bed, board, and nursing care, in order that the whole financial structure of the service plan be not jeopardized.

Radiologists of Milwaukee and the State of Wisconsin have no desire to withhold their services from patients hospitalized by benefit of their subscriber contract with Associated Hospital Services. Why should they, when that is the very function for which they have been especially trained? However, we do not consider it a fair deal to the patient if the medical service benefit is not given in cash either to him or by waiver from him to his physician, since the time may come when that Hospital Service Corporation will not be able to pay in full its share of the medical expenses incurred by the hospitalized patient. At that stage of the game service tends to become "watered," and the patient is no longer receiving the "latest scientific advancements in medicine" because only reduced funds are available. It has long been an axiom in the practice of medicine that diluted medical service is not good medical care.

Let it be reiterated that if Associated Hospital Service not only is desirous of paying for bed, board, and nursing to the extent of a $3.50 room for a minimum of twenty-one days per calendar year, but desires in addition to pay for certain special medical services of the radiologist, pathologist, electrocardiologist, and anaesthetist, no member or group of the profession will have any just right to criticize the plan *if* the medical services included are in the form of strictly cash benefits. Just so long can the patient be assured of getting what his contract calls for. This is not a matter of theorizing but a matter of actual fact from past experience in this country and in other countries with group hospitalization. If the truth is desired let it be known that the majority of hospital service plans functioning in the United States today do not include the services of the radiologists, either in the form of cash benefit or in the objectionable form of straight per diem payments from the service corporation to the member hospital. Those which have kept strictly to the providing of bed, board, and nursing only by the Hospital Service Corporation have "gone along" with the least difficulties and have the largest percentage of the population covered in several instances, for under these circumstances the service becomes available to the largest possible number in the low-income group. Actual experience disproves the argument that it is necessary to include such medical services in order to sell the insurance.

In Wisconsin's sister State, Michigan, there is being sold, side by side with medical care insurance, the hospital insurance contract, providing strictly for the sale of hospital service only, and the medical insurance contract, providing the care of the general practitioner and specialist alike, including, of course, the radiologist and pathologist, whether his services be given in the office, the home, or the hospital. This, unquestionably, is a superior plan from the standpoint of both the patient and the physician, for it wisely provides that the administration of the hospitalization service be under the direction and control of hospital administrators and others who are experts in this field, but it gives a controlling voice in the provision of the medical service to the doctors and not to hospital administrators or to lay boards of control.

Isn't it absurd to contend that if the average patient has his hospitalization costs paid, including fifty per cent of the charges for diagnostic X-rays and fifty per cent of the laboratory charges, he will easily be able to take care of any and all items not covered in the services which he receives, either medical or non-medical, in the hospital, but if that fifty per cent item for the abovementioned medical services is excluded, it will create an unbearable burden to the individual?

Let us look at the facts. In the patients hospitalized in any average hospital today, and by that we mean, of course, to exclude ambulatory patients who come in for diagnostic X-ray or laboratory purposes only,—such individuals quite obviously not intended to be covered by the present hospital insurance contract,—we find that something less than a majority of the patients have any diagnostic X-ray service whatsoever. And we find, furthermore, that the average charge for those patients who do have diagnostic service is $10.00 or $15.00. Now, if a fundamental principle is involved, of medical services being dispensed or at least controlled by the Hospital Service Corporation, and if, furthermore, the special Enabling Act authorizing the formation of hospital service corporation states specifically that the corporation "shall provide for hospital services only and shall not embrace medical services," is it really doing the individual subscriber such a large service in insisting upon including in the hospital benefit fifty per cent of the cost of any diagnostic X-ray services and fifty per cent of the cost of laboratory tests, basal metabolisms, and electrocardiograms?

We need touch only lightly upon the matter of such a plan as has been evolved by Associated Hospital Service of Milwaukee, putting "pressure" on both the patient and the attending physician alike to make use of diagnostic services which can be bought, insofar as the patient's pocketbook is concerned, for fifty cents on the dollar. We would only point out that it would be much better for Mr. Jones or Mr. Brown, the holders of subscriber contracts, if they could get not just the services of the radiologist or pathologist but services of the urologist, orthopedist, the surgeon, the eye, ear, nose, and throat specialist, and the general practitioner for fifty cents on the dollar. Under these circumstances we would have "fifty per cent medical insurance coverage," and the pressure would be relieved from the attending physician to request a "cheap (?)" diagnostic X-ray examination for which the patient pays only fifty cents on the dollar, when he might be better off to get a one-hundred-cents-on-the-dollar cystoscopic study by the urologist or sigmoidoscopic study by the surgeon. If Associated Hospital Service is desirous of paying not merely for the basic services, which it supplies itself, of bed, board, and nursing, but for the services of physician as well, why not treat all physicians alike and give cash benefits as the patient needs them to his family physician who takes the patient to the hospital, to the surgeon who takes out his appendix, or to the X-ray specialist or pathologist who aids in diagnosis of the disease prior to surgery?

If radiologists were essentially selfish in this matter of medical services included by Associated Hospital Service, they would do well to keep "mum," since for the present at least it would appear that Associated Hospital Service is "playing favorites" with them and their fellow physicians, the pathologists, anaesthetists, and the electrocardiologists. Those who have made a careful study of hospital insurance benefits in this country and in foreign countries realize, however, that it is extremely dangerous to include loosely an unlimited amount of medical care along with a restricted amount of tangible, predictable cost hospitalization benefit because of the great danger to the patient or the subscriber, that sooner or later the time will come when he will find that he has been paying for something that he no longer receives.

If no issue is made at the present time concerning the inclusion of medical services which Associated Hospital Service now offers the subscriber, there can be no "hue and cry" raised one, two, or three years hence if Associated Hospital Service wishes to include diagnostic urology, diagnostic enterology, or any other diagnostic service which the general practitioner or specialist is now giving to hospital patients. If the inclusion of fifty per cent of the costs of an unlimited amount of diagnostic radiology and laboratory service is not a direct violation of Clause C of the Enabling Act 288 S. then neither is the inclusion of the diagnostic service of any other practitioner of medicine in violation of the Act.

Radiologists have no desire to "go it alone." The stand which they take regarding

hospitalization insurance in Wisconsin is not original with them. It is the studied thought of radiologists and pathologists the country over, and it has the official endorsement of the Council on Hospitals of the American Medical Association. Rather, radiologists desire to "go along" with the medical profession as a whole, and when medical sickness insurance comes to Milwaukee and Wisconsin the radiologist, like all of the other groups of medical practitioners, will boost it strongly, if it is offered on a sound financial basis and also upon recent intensive studies of the insurance aspects of The State Medical Society of Wisconsin. Only under such circumstances can they rest assured that all safeguards have been placed about the plan to permit the individual's receiving "the latest scientific advancements in medicine" the first year, the second year, and every year thereafter.

Senator Bilbo of Mississippi Proposes a "Doctor's Day"

Mr. Bilbo. Mr. President, a few days ago I introduced Senate Joint Resolution 256. The joint resolution was referred to the Committee on the Library, and has been favorably reported, and is now on the calendar as No. 1695. The joint resolution provides for the designation of a day to be observed as Doctor's Day. I shall read the joint resolution:

Resolved, etc., That the 22d day of June in each year is hereby designated, and shall hereafter be known as, Doctor's Day in commemoration of the great sacrifices and untiring efforts and devotion of the members of the medical profession in performing their duty to humanity by caring for the sick and injured in times of individual need and during periods of pestilence, war, and other disasters and catastrophes.

SEC. 2. The President is authorized and requested to issue annually a proclamation calling upon officials of the Government to display the United States flag on such day and inviting the people of the United States to observe such day in an appropriate manner.

Mr. President, I wish to make a few observations in connection with the joint resolution.

History and literature, both sacred and profane, ancient, medieval, and modern, assign to the physician—to the ministry of healing—a place high on the scroll of man's achievements.

Hippocrates, the Father of Medicine, who lived 400 years before Christ, attained immortal fame through his great works as a physician. As a youth he studied the tablets in the temples of the gods, where each person inscribed the ailments from which he had suffered and the means by which he had recovered. History tells us that at the beginning of the Peloponnesian War Hippocrates saved Athens from a dreadful pestilence. Subsequently, upon being invited to the court of Artaxerxes, he patriotically refused, and said he must serve his own country. He was given the civic privileges of Athens and was rewarded with a golden crown. Down through the ages the noble principles practiced and expounded by the Father of Medicine have survived to mold the ethics of all physicians worthy of the name. No finer human document was ever written than the Hippocratic oath. The following passage of that oath reflects particularly well the philosophy of the ethical physician. I quote:

I will look upon him who shall have taught me this art even as one of my parents. I will share my substance with him, and I will supply his necessities, if he be in need. I will regard his offspring even as my own brethren, and I will teach them this art, if they would learn it, without fee or covenant. I will impart this art by precept, by lecture, and by every mode of teaching, not only to my own sons but to the sons of him who has taught me and to disciples bound by covenant and oath according to the law of medicine. The regimen I adopt shall be for the benefit of my patients, according to my ability and judgment, and not for their hurt or for any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such; and especially I will not aid a woman to procure abortion. Whatsoever house I enter, there I will go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any act of seduction of male or female, bond or free. Whatsoever thing I see or hear concerning the life of man in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as a sacred trust.

Nor does the doctor's code of honor stop with the oath. Since earliest times the medical profession has developed and codified ethical principles to which every good doctor adheres. The code is to him the highest law in the universe outside of the Bible. In truth, in his ministrations to humanity, the doctor exemplifies in high degree the very spirit of the Saviour Himself, who came to earth with healing in His hands.

The doctor's relation to his patrons differs from that of any other profession or business. He is brought in direct contact with the family in a relationship the most intimate as well as the most sacred and serious that falls to the lot of man. He is with us at birth, through life, and at that final hour when the eye is closed in darkness, the nerveless hands crossed in dreamless sleep upon a pulseless breast.

Let us suppose that he has done the practice of a family for a number of years. He has been present at the birth of the children of the home; has taken them through their teething, measles, mumps, and

* Reprinted from The Congressional Record—Senate, for May 20, 1940, pp. 9791–9793.

myriad other childhood diseases or injuries. He has stood by the mother at the most serious times, when an error or bad management on his part would have left a helpless household bereft of its dearest friend —the mother. He has sat night after night in the dangerous illness of the father with his finger on the pulse, probably administering the remedies with his own hand and remaining to note the effect. The mother and father rightfully hold the family doctor above all others in high esteem and teach the little ones from their first lispings to speak the doctor's name in reverence, to believe that he is the greatest and best of earth's noblemen. And he is the greatest and best of earth's noblemen in his relation to the family.

I presume there is no one in this presence today who does not cherish the memory of a "family doctor." I presume there is no one who cannot even now visualize the faithful, efficient doctor at the bedside of a loved one in the throes of grave illness and agony, in the very shadow of death itself, with that eternal sleep from which no man returneth approaching ever closer. I say with impunity, I believe, there is not one among us who has not abundant incentive to invoke a tribute to some fine minister of healing who with ingenious mind and strong but tender hands has assuaged the pain, rebuked the fever, and prolonged the life of someone dear to us. Or, having done all that he could without avail against Nature's inexorable law of death, he remains there even unto the last—a bulwark of comfort and counsel to the sorrowing ones. Ah, yes, my colleagues, I think you know the picture I am so feebly endeavoring to depict. The faithful, fearless doctor — humanity's noblest benefactor!

It is not for his physical benefactions alone that I would honor the doctor. The inherent virtues which his life epitomizes deserve their eulogies, too.

Whenever I look upon a statue or a monument erected to the great and honored, to achievement or ideal of whatever kind, somehow I cannot escape the analogy which that monument or statue evokes as symbolic of the doctor's life. Our beloved Statue of Liberty itself summons to mind the ideals characteristic of the worthy doctor's philosophy. Members of the Senate know the words of the inscription on the pedestal of the Statue of Liberty, I feel sure; but I quote them here because they merit oft repeating:

Give me your tired, your poor,
  Your huddled masses yearning to breathe free,
The wretched refuse of your teeming shore;
  Send these, the homeless, tempest tossed, to me;
I lift my lamp beside the golden door.

Who lifts higher his "lamp" than does the doctor, to diffuse light and comfort into the dark corners of despair where dwell the wretched, huddled masses, or into the deep valley of the shadow?

When duty calls, the doctor is no respecter of persons. Into the lowly hut of the poor, the hut made lowlier still by the attrition of hard fortune, neglect, and perhaps the harshness of scorn, the doctor carries his gift of healing even as into the imposing mansion on the verdant hill. Amid poverty or splendor, cold or warmth, the brave soul clings to its supreme loyalty to principle. The surgeon wields his instruments with equal precision and dexterity whether his patient be peasant or patrician, homeless waif or scion of the rich.

Who is democratic if the doctor is not democratic? Who is humane if the doctor is not humane?

More is the credit due him when we consider the economic cost and the personal sacrifice on the part of the doctor in obtaining his medical education, in pursuing the practice thereof. We all know that he spends more years in study than his contemporaries in other occupations, and he pays more for it. It is a matter of record that the average cost per credit hour for the medical student is almost $27 compared to the average of $11 for law courses and $4 for teaching. But, alas, his remuneration is less than that of almost any other specialized profession, when the average is considered. Out of his earnings he must take special courses from time to time, buy expensive books, and the like, in order to keep abreast of all that is new in technique and improved medical science. He must have expensive equipment if he is to be successful. He must know his art and be able to execute it. For though art be long, life is short, and the crisis fleeting. Human life is precious and the doctor worthy of his name is not content that his patients shall have anything but the best the medical profession can give. In the giving of his talents he is the most charitable of citizens. Any public-welfare society will attest that the doctor contributes more freely of his time and talent to charity than do his fellow citizens, and he often gives from his purse as well.

His sacrifice of personal leisure and risk of personal health are great indeed. Improved facilities, broader education of the masses, and the other amenities of our present civilization have mitigated the doctor's hardships and difficulties in no small way, but still his sacrifice is great. He must rule out of his life nearly everything that does not relate to his profession—everything not conducive to efficient performance of his calling. In times of epidemic, at the risk of his own life, he goes among the sick and dying. In times of disaster, he works day and night administering to the victims. In time of war he proves himself among the bravest of the brave warriors as he toils to assuage the agonies of wounded, dying soldiers, to repair as best he can the horrible damages done by cruel instruments of war.

Picture, if you can, Mr. President, a scene more heartrending in its horror, more challenging to the physician's skill and endurance, than that scene which is part and parcel of every war that was ever waged—wounded, agonizing, groaning, dying soldiers, drenched in blood, steeped to the lips in utter misery and despair, longing perhaps for death's release, but loathe to desert their posts of duty. I would not, if I could, by word or innuendo, take aught from the chivalric honor of the soldier on the battlefield. I would not dim the glory won in peace

or in war by any patriot. I yield to no one in my obeisance to the humblest of war's heroes, living or dead. I only say that in war, as in peace, the doctor takes his place among the bravest of the brave.

Who is self-sacrificing if not the doctor? Who is brave if the doctor is not brave?

To physical exertion is added the mental stress—the harrowing experience of witnessing pain and sorrow. Though the doctor must necessarily summon the philosophy of a stoic as his pathway leads him through Sorrow Lane, we are mistaken if we think that he becomes inured, insensitive to its pathos. Once as a fine physician emerged from a home where the death angel had just entered, I asked this stalwart, firm-faced man to tell me, if he would, something of the feeling that the doctor takes away with him from the scene of death. Here is, in substance, what he said to me:

"When I was called to this home today, I found the handsomest and most loved youngster of this family in the very throes of death. It was my duty to inform the family that the little boy was dying. Of all the painful duties that a doctor is called upon to perform, this, to me, is always the most painful. It would be impossible to describe the anguish and the pathos of this bereaved household. Oh, what bitter agony it costs to surrender a precious life to the Grim Reaper."

The doctor sees men and women at their weakest and their worst. But he must carry on calmly, capably, unerringly, despite all the forces that challenge or harass his faculties. His love of mankind and the devotion he receives from grateful patients extenuate but cannot make restitution for his physical and mental sacrifice. So it is that the average doctor does not attain the allotted 3 score years and 10. The life expectancy, or life span, of the doctor has lengthened somewhat in recent years, and I thank God. I do not have national data on the causes of death among doctors, but it is of record that about half the doctor deaths in Mississippi last year were attributed to heart failure. Brave soldiers to the cause of humanity right to the last, most of them. I like to think that death came to each of these—

Not like the quarry slave at night
Scourged to his dungeon, but sustained and soothed
By an unfaltering trust, approaches his grave
Like one who wraps the drapery of his couch
About him, and lies down to pleasant dreams.

Though the average life span of the doctor is far too brief, Providence spares a few of these ministers of healing unto a ripe old age. I was inspired when I read of such a case in a recent newspaper article. The reporter described a venerable physician in a small mining town in Alabama, the typical rural doctor, I take it, and he is the only practicing physician in that little town. He is said to have had only two vacations in his entire 60 years of practice. His family had been persuading him to go to a hospital for a rest. He scorned the idea of retiring or taking a rest. But at long last he consented. His son drove down from Birmingham to take the good doctor to the hospital. Just as they were departing they were halted by a man in great distress. The man wanted the doctor to come quickly and attend the wife who was then come to her hour of travail. The aged doctor climbed out of his son's car, gathered up his medicine bag, and laconically announced:

Guess we'll have to cancel the hospital trip, son.

Where could one find a more inspiring or a more human portrayal of the doctor's contribution to humanity?

Here was this dear old gentleman whose feet are brushing the dews on the shores of the River Jordan, whose crossing to the other side cannot be far distant, and yet he abandoned thought of self to answer the call of that poor woman in travail, to usher into this world another precious life.

Who is long suffering if the doctor is not? Who is loyal in his service to others if the doctor is not loyal? Who is persevering if the doctor is not persevering?

Had I the fluent and eloquent pen of the immortal Robert Louis Stevenson I could more adequately pay just tribute to these noble humanitarians I would have us honor. Stevenson said in his eulogy of the doctor:

There are men and classes of men that stand above the common herd—the soldier, the sailor, the shepherd not infrequently, the physician almost as a rule. He is the flower of our civilization and when that stage of man is done with, only to be marveled at in history, he will be thought to have shared but little in the defects of the period and to have most notably exhibited the virtues of the race. Generosity he has, such as is possible only to those who practice an art and never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage. So it is that he brings air and cheer into the sickroom, and often enough, though perhaps not so often as he desires, he brings healing.

I agree with the immortal Stevenson that the doctor is the flower of our civilization; and it occurs to me that the time has come when we should designate a day—a day apart from all the other days of the year—to honor the worthy noblemen of the medical profession, the most unselfish humanitarians that grace the earth with their noble deeds.

Following a fine custom of our times, should we not designate a Doctor's Day as a counterpart of Mother's Day, Father's Day, and other days on which we pay special tribute to persons or to causes? I think that your dear mother, Mr. President, if you be so fortunate as to have her on earth today, would smile with approval at such an act on the part of our assembly. Though it is my sad lot to wear the white rose on Mother's Day for the sweetest of mothers, now with the saints, I doubt not that if she could speak to me from the celestial sphere of Heaven she would voice her approval.

And so I bow, my distinguished colleagues, and implore you that this Seventy-sixth Congress of our

United States shall designate and decree a day set apart out of each year as a tribute, a symbol of gratitude, to the flower of our civilization—the doctor.

It seems to me altogether fitting, and simple poetic justice would seem to demand, that this long-belated recognition be conferred; that we should duly create, and record among the memorabilia of our great Nation, a day of commemoration for the great cause the doctor represents, that the observance of Doctor's Day may become a part of the customs of our enlightened age, a day of observance not only for the people of this age but even unto posterity.

Mr. President and gentlemen of the Senate, permit me earnestly to urge the passage of this joint resolution, so that at least one day in each and every year shall be dedicated to the doctor, humanity's greatest benefactor, and upon that day may every citizen send a card, a telegram, or a letter of love and appreciation to the family doctor; call him over the telephone, and speak words of thanks and appreciation; send him flowers or other appropriate tokens of love and friendship; or, better still, drop in at his office or his home, and personally convey to him a message of esteem and gratitude.

Low Cost Legal Services*

By RUDOLPH A. SCHOENECKER, ESQ.
Milwaukee

AS CITIZENS we all have certain inalienable rights under the Constitution. In order to give those constitutional guarantees practical effect, three different economic groups must have ready access to justice: the rich, the intermediate class, and the poor. Or, since we are to discuss the matter of fees, let us classify the groups as including those who can pay a full fee, those who can pay only a small fee, and those who can pay no fee. Our topic today covers the availability of justice to the second class, the low income group, and the need of establishing a so-called low cost legal service for individuals in that bracket.

The general low cost legal plan submitted presupposes that justice can be obtained only for a price, and that the price is beyond the reach of that class of our citizens. That assumption, ladies and gentlemen, is grossly erroneous, as I shall establish later on. But let me digress for a moment to explain the proposals as I understand them.

A few years back the National Lawyers Guild sponsored the idea of giving low cost legal service to the low income group. Plans have now been devised and will shortly be put into operation in Philadelphia and Chicago.

The Philadelphia plan contemplates the establishment of decentralized law offices in various neighborhoods in and around the city where no practicing attorneys are situated. It provides that able and well trained young attorneys offer general practitioner service in all civil matters at moderate standardized fees.

The Chicago plan as originally conceived, visualizes the creation of a central legal bureau, operated by competent salaried attorneys, under the supervision of the bar of the city. It is to be the function of this bureau to engage in, explore and develop fields of legal services required by society, but not furnished by the legal profession. As one of its duties it is to attempt to educate the low income groups and the public at large about their needs for legal services. With this latter purpose I have no dispute.

The details of one of the Chicago plans appeared in the October, 1939, issue of the *National Lawyers Guild Quarterly.* In its scope and purposes I assume that it gives us the general pattern followed by all the plans.

It is proposed that several attorneys organize a partnership and establish a central office. A staff of nineteen attorneys of different ages and years of experience will be hired at a sliding scale, ranging from $1,000 a year for the youthful graduate to $7,500 annually for the top man. It is estimated that the office can be operated on an annual budget of $72,000. Since the office is to be self-sustaining, it appears that nineteen attorneys must earn $72,000 each year. Assuming that each attorney has a productive capacity of 1,500 hours per year (or an average work day of five hours, after allowing each attorney one month's vacation) this

* As presented on the Milwaukee Junior Chamber of Commerce Town Forum program over radio station, W.T.M.J., Milwaukee, March 10, 1940.

means that each must earn in excess of $2.25 per hour during the year in order to meet the budget. Having thus determined the cost of operation, a fee schedule is then computed. With few exceptions, no set price is established for the handling of one particular case, such as a divorce or a foreclosure. On the contrary, work is paid for on an hourly basis, starting at a minimum of $2 for the first one-half hour of office conference. Court appearances are paid for at the rate of $5 per hour. Those are the fees established to make legal services available to a low income class, which includes any person earning less than $2,000 per year.

It is admitted in the article that such low cost services could not prevail without a large volume of business. In order to acquire such volume an extensive publicity campaign will be launched to acquaint the public with this noble enterprise.

The article closes on a most optimistic note. It is expected by its sponsors that the plan will not only be self-supporting, but will actually be operated at a profit. Such profit will first be used for more advertising, which will be done, I assume, to create more volume, to create more profit, which will finally be divided proportionately among the partners.

Well, it's a splendid plan,—but for the lawyers sponsoring it, and not for the group to be helped. I, too, would very much like to organize a partnership, set my own salary at any figure, adjust my fees to that sum needed to meet expenses, and then advertise to the world at large that I'm in business, and by such advertising build up sufficient volume to guarantee my overhead. That would be perfect. And it's all to be done under the guise of helping our poor unfortunate brethren who cannot afford to buy justice and cannot purchase legal advice.

Ladies and gentlmen, I think the plan is vicious simply because its sponsors have lost sight of the benevolent purposes in which it was conceived, and have permitted themselves to be carried away by their honest enthusiasm down the path of commercialism which has no place in our profession. The plan must be condemned for the following reasons:

1. By making the unit self-supporting, the problem was necessarily approached from the standpoint of the lawyer and his needs rather than the needs of the low income group to be benefited. This places the cart before the horse; in helping the low income group the only logical starting point is the amount which an individual in that group can afford to pay. Any other approach will result in a commercialization of our profession.

2. Contrary to the profession's accepted standards, the plan proposes to advertise to the public the availability of its services, thereby attracting clients not because of the ability or integrity of its staff, but solely because of the advertising.

3. Such advertising would certainly constitute unfair competition with other attorneys who cannot advertise, and it would necessarily foster a monopoly of the practice from the low income group.

4. The so-called low fees proposed are very little different than the existing schedule of the Bar Association, and are actually in excess of the fees charged by many in the profession today.

Finally, there is just no need for such plan in this community because a vigilant court and an active Bar Association have kept the doors of justice open to all, and have made legal advice available to rich and poor alike. We don't buy justice in Milwaukee, or in Wisconsin; we have it given to us as a matter of right!

Daniel Webster said:

"Justice is the greatest interest of man on earth. It is the ligature which holds civilized beings and civilized nations together. Wherever its temple stands, and so long as it is honored, there is a foundation for social security, general happiness and the improvement and progress of our race. And whoever labors upon this edifice with usefulness and distinction, whoever clears its foundations, strengthens its pillars, adorns its entablatures, or contributes to raise its august dome still higher to the skies, links himself in name, fame and character with that which is, and must be, as durable as the frame of human society." *Hepp vs. Petrie, 185 Wis. 350 at 358.*

And we lawyers are ministers in that temple, not money changers. Ours is a pro-

fession, not a business. The highest court of our state has this to say:

"The standard should be raised rather than lowered, for the age in which we live is one which is much concerned with money and the things which money will bring. The fact that the lawyer must support himself by his professional labors and that he receives his compensation from a purely private source unquestionably has a tendency to commercialize his work and obscure even from his own mind the fact that his real client is Justice. To successfully combat this tendency we must have lawyers who not only say but really believe that they *are* ministers of justice and not men hired by their clients to circumvent or outwit the law.

"The ideal here expressed is high, it is by no means always lived up to, but it is none the less the ideal towards which the profession should ever strive. It is because the ideal is frequently lost sight of, because many lawyers practice their profession as if it were a mere business like the buying and selling of groceries, that the profession falls into disrepute." *Ellis vs. Frawley, 165 Wis. 381, 383.*

Mr. Chief Justice Winslow, who did as much perhaps as any other one man has ever done in this state in building up professional ideals said:

"It is one thing to enter a *business* with the idea of gaining a livelihood or acquiring wealth thereby; this is perfectly honest and legitimate, but it is in no sense ennobling. It is quite another thing to enter a *profession* with the conviction that it is charged with the great public duty of administering justice, and that its leaders in the past have swayed the minds of their fellow citizens in the greatest affairs of life and led democracy's battle wherever waged; this thought is inspiring, it involves a consecration to duty, a conception of the lawyer's work not as mere money getting but as service of the highest order, not as a mere occupation, but as a ministry." *Hepp vs. Petrie, supra.*

And Mr. Chief Justice Ryan said:

"These are high ideals and noble sentiments. There are not wanting, in these times of unrest and change, many cynics who are willing to scoff at what they deem to be unrealities and who ignore, if they do not despise, spiritual values. However, it must not be forgotten that the foundations of our government were laid by men who were devoted to principles and ideals and that upon these principles and ideals our national success has been builded. If we are to maintain ourselves we must maintain our ideals.

"No nation has ever become great through material things alone. It is when people have been willing to sacrifice unstintingly for their principles and their ideals that nations have experienced their greatest advance, and a particular and peculiar responsibility rests upon the Bar and the Bench of this country, and any conduct which tends to lower the standards and corrupt the ideals of the Bar or to destroy the confidence of the public in the legal profession should meet with the most emphatic disapproval and reprimand from all right-thinking members of the profession, and particularly from the courts." *Hepp vs. Petrie, supra.*

The profession has embodied those principles and ideals in a Code of Ethics which sets forth governing rules of conduct and standards of practice existing inarticulately since the beginning of the bar.

The Canons of Professional Ethics were first adopted by the American Bar Association at its thirty-first annual meeting at Seattle, Washington, on August 27, 1908. The purpose for the adoption of the Code is found in its preamble, which reads in part as follows:

"In America, where the stability of Courts and of all departments of government rests upon the approval of the people, it is peculiarly essential that the system for establishing and dispensing Justice be developed to a high point of efficiency and so maintained that the public shall have absolute confidence in the integrity and impartiality of its administration. The future of the Republic, to a great extent, depends upon our maintenance of Justice pure and unsullied. It cannot be so maintained unless the conduct and the motives of the members of our profession are such as to merit the approval of all just men."

Section 256.29 of our Wisconsin statutes sets forth the oath which each attorney is required to take prior to his entry into the profession. The oath is administered by the Supreme Court of the State of Wisconsin. Its final clause reads:

"I will never reject, from any consideration personal to myself, the cause of the defenseless or oppressed, or delay any man's cause for lucre or malice. So help me God."

Those are the standards set for us by our highest judicial tribunal, by our own Code of Ethics, and by our own Legislature. How can it be so easily assumed in the face of such requirements that justice is being denied to some of our citizens because of inability to pay legal fees!

That situation just does not exist here because under Canon 12 of the Code of Ethics it is provided:

"In fixing fees it should never be forgotten that the profesison is a branch of the administration of justice and not a mere money-getting trade."

By general consent and actual practice there is taken into consideration in fixing fees, not only the attorney's experience, not only the amount of work involved, not only value of the case to client, but the ability of client to pay.

The belief that attorneys generally charge exhorbitant fees is as untrue as it is popular among laymen. Well, let's see what the record shows. A check of the income tax returns of lawyers in Wisconsin shows that in the boom year of 1929, 36 per cent of them were earning less than $2,000 annually, and this percentage increased yearly until in 1937 it reached 48 per cent. In Milwaukee for the period 1927 to 1932 it appears that out of all the attorneys practicing six years or more, 45 per cent of them had an average income of $3,000 or less. And I dare say that the bulk of those incomes was derived not from one or two big cases, but from a modest volume of $2, $5 and $10 fees. Those are the tremendous incomes of attorneys, based upon their exhorbitant fees!

In the face of those figures it cannot very well be said that there is a present need to furnish legal service to our low income group. That group already has legal service, and will continue to have it as long as the ideals of our profession remain. I say without fear of contradiction that no one in this community has ever suffered a miscarriage of justice, nor been left wanting for legal advice simply because he could not hire an attorney.

In addition to this, and contrary to popular conception, we have public and governmental agencies which cater to the requirements not only of our indigent class but also to some extent of our low income or needy class.

Over a quarter century ago the Bar Association with the help of civic minded individuals helped to incorporate the Legal Aid Society of Milwaukee. It is presently located in the Safety Building, and is supported and maintained by a grant from the local Community Fund.

The Society was incorporated for the purpose of rendering "legal advice and assistance *free* to persons who cannot afford to pay for legal service." According to its latest available statistical report, covering the period from October, 1937, to October, 1938, it serviced the legal needs of 3,469 people in the community. Besides being given legal advice, clients are represented by competent counsel in court with no charge of any kind to the client.

All this work was done by a permanent staff of two people and an attorney who rendered part-time service, on a budget for the period of $5,858.34, or a cost per case handled and closed of $2.12. No clients eligible for relief were turned away. The facilities were adequate to cover all requests.

Under its rules the Society does not take cases for people who are financialy able to pay an attorney. The Society is the judge in determining whether a client is entitled to service. This does not necessarily mean that the applicant be out of employment at the time; nor does it mean that the applicant be on relief. The facts and circumstances establish the rule in each case. It is significant that out of the 3,469 cases handled during the last fiscal period, only twenty-four were rejected for the reason that they were *fully* able to employ counsel.

Even more significant is the record showing who referred the applicant to the Society. Only thirty-one out of the entire number of cases handled were referred to the agency by attorneys. Stating the matter another way, the lawyers of Milwaukee refused legal aid to only thirty-one individuals out of a community of over 600,000. And by such refusal I do not mean that the thirty-one were denied legal counsel; they were merely turned over to an agency created especially by the profession for their type of case. If this doesn't refute the claim that the low income group is not being properly treated, I miss my guess.

In addition to the work done by this publicly supported agency, we find that the Government has authorized various public bodies to render legal aid free of charge to various groups, without regard to their abil-

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ity or inability to pay a lawyer. Foremost among these is the Industrial Commission, where a working man can receive aid in his wage claims; the income tax office, where a staff of employees will assist in preparing tax returns; the criminal court system which provides for the appointment of a voluntary defender in certain cases; the probate court system, which administers small estates free of charge; the circuit court system for the appointment of attorneys to prosecute debtor relief cases for a nominal charge; the creation of a civil court and its small claims branch for minor matters. And so one may go down the line of governmental services, all created for and granted to not only our indigent group, but to anyone who wishes to avail himself of them. In the face of such record where is the need for low cost legal service to any group!

Let it be clearly understood that the profession generally appreciates its responsibility to the community. One who must invoke the aid of the law, but has no money for counsel fees or court costs, nevertheless has an inviolable right to redress under the constitutional guarantee to every citizen of the equal protection of the laws. To none, rich or poor, should government sell or delay or deny justice. The Constitutional safeguards given to the lowliest of us as a matter of right would be a grim mockery were the key to set the machinery of justice moving, in enforcement of such rights, denied for lack of money. I say that as long as we have among us attorneys worthy of the name, so long will we have justice for all.

Idealogically, the plan proposed by the National Lawyers' Guild is splendid. Actually, ladies and gentlemen, it is already in existence in this community.

Prematurity as a Factor in Wisconsin Infant Death Rates

By AMY LOUISE HUNTER, M.D.
Chief of Bureau of Maternal and Child Health Wisconsin State Board of Health Madison

KNOWING that adequate prenatal care aids in reducing the number of babies born prematurely, educational programs of the health agencies have been directed in an attempt to educate mothers to place themselves under the care of their physicians early in pregnancy. Many public health nurses have worked cooperatively with local practicing physicians by carrying informational programs on maternal and child care into the homes of expectant mothers. In 1939 practicing physicians in the state referred directly to the Bureau of Maternal and Child Health 2,680 of their patients for the prenatal letter service. The purpose of this service again is to encourage routine medical care throughout pregnancy. The monthly letters going into the homes encourage expectant mothers to return for their routine visits. During that same year public health nurses within the state made 8,519 educational visits to expectant mothers. Where deliveries were to be in the home mothers were instructed in the preparation

The type of incubator distributed in Wisconsin by the Bureau of Maternal and Child Health of the State Board of Health.

The Patient With Mild Depression

THE patient with mild depression usually presents a clinical picture characterized by the following symptoms:

> (1) apathy, discouragement and undue pessimism; (2) subjective difficulty in thinking, in concentrating and in initiating and accomplishing usual tasks; (3) subjective sensations of weakness and exhaustion; (4) hypochondria (undue preoccupation with vague somatic complaints such as palpitation or gastro-intestinal disorders which may have no organic basis).

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of the home for delivery and aid was given in seeing that any supplies requested by the local physician were in readiness. These nurses also reported more than 25,000 home visits in behalf of infants in 1939.

Wisconsin ranks as a favored state in low infant and maternal mortality rates. The 1938 figures showed the state in eleventh place with low infant deaths and in sixth place among the states for low maternal deaths. What has been achieved in Wisconsin depended upon the excellent medical care available practically everywhere in the state and upon the educational programs of the state and local health agencies and those groups cooperating with them.

The possibility of further reduction of infant deaths in Wisconsin is challenging because we find that about two-thirds of the infant deaths occur in the first month of life and that half of these are the deaths of premature babies. In 1938, the last year for which official figures are available, our infant death rate was 42.2 per 1,000 live births, the lowest rate ever reached in Wisconsin. This rate was based on a total of 2,308 infant deaths. Of this total, the cause of 753 deaths, or 32.6 per cent, were assigned to prematurity. (See the accompanying statistical table.)

Wisconsin Births and Premature Deaths—1938
(Resident Figures)

	Urban	Rural	Total
Live births	27,749	26,997	54,746
Born prematurely:			
Under 6 months	44	27	71
Six months gestation	116	118	234
Seven " "	347	259	606
Eight " "	498	350	848
Total prematures	1,005	754	1,759
Per cent of live births born prematurely	3.6	2.8	3.2
Deaths assigned to prematurity	402	351	753
Total infant deaths	1,136	1,172	2,308
Per cent of deaths due to prematurity	35.4	29.9	32.6
Infant death rate per 1,000 live births	40.9	43.4	42.2

Undoubtedly many other premature babies died from known causes so we can assume that of the total 1,759 births recorded as premature, 50 per cent or more must have failed to survive.

Premature deliveries usually occur unexpectedly. Records for 1938 show that 1,005 of the 1,759 occurred in cities and 754 occurred in rural areas. Undoubtedly most of those deliveries occurring in cities took place in hospitals where good nursing care is available and where an incubator, if it is not already a part of the hospital equipment, can be improvised. In the home often there is no one other than the doctor to take charge of the infant and to aid in providing an environment in which the baby may have a chance to survive. With this in mind the Bureau of Maternal and Child Health of the State Board of Health has recently had made forty incubators which can be used by physicians for the care of premature babies born in homes. These incubators are assigned to nurses in counties in which numerous home deliveries are occurring. When an incubator is needed, the public health nurse will be able to aid the physician by teaching the person caring for the mother adequate nursing care in the home and by demonstrating the use of the incubator. When there is need for an incubator in a county to which one has not been assigned, the request may be referred to the district health officer of the district in which the county is located.

These incubators are of wood construction and can be reproduced by local jobbers, the cost of materials, including the thermostat, being approximately $12. They are painted with lead-free paint and have thermostatic control for use if there is electricity in the home. With this means of heating the incubator, the thermostat is adjusted so that at a room temperature of approximately 72–75 F. a 40-watt bulb will maintain the incubator at any temperature between 85–90 F., as desired. Where electricity is not available, heated bricks, hot sand, hot water bottles, or soap stones, placed in the drawer at the bottom of the incubator, supply artificial heat.

Before releasing the larger number of incubators a few were tried out in the state with very satisfactory results, and we feel that some lives will undoubtedly be saved by the availability of the incubators. More, however, will be accomplished by the interest and knowledge which is stimulated and spread through the emphasis which is placed upon these programs. We hope that the phy-

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sicians in the state will call upon local nurses whenever need arises because even if incubators are not available, the public health nurse can assist a great deal by teaching the proper nursing care in the home.

The location of incubators is as follows:

Assigned to County	Location	Public Health Nurse	Address	City
Adams	Adams-Friendship Hospital	Dorothy Willis	Courthouse	Friendship
Ashland	District Health Office	Margaret Thiel (District Advisory Nurse)	Vaughn Library Building	Ashland
Barron	M. and C. H. Office	Louise Steffen	Courthouse	Barron
Brown	Sheriff's Office	Eleanor O'Meara	Courthouse	Green Bay
Brown	District Health Office	Helen Grant	Courthouse	Green Bay
Chippewa	District Health Office		Rutledge Charities Building	Chippewa Falls
Chippewa	District Health Office		Rutledge Charities Building	Chippewa Falls
Chippewa	Cornell Fire Station	Cordeal Willkom	School Nurse	Cornell
Clark	County Nurse's Office	Mrs. Elizabeth Stewart	Courthouse	Neillsville
Dane	Sheriff's Office	Miss Carolyn Schlattman and Mrs. Irma R. Williams	119 W. Main	Madison
Dodge	County Nurse's Office	Alberta Anderson	Courthouse	Juneau
Door	County Nurse's Office	Ruth Brye	Courthouse	Sturgeon Bay
Florence and Forest	Ovitz Hospital, Laona	Jessie MacDonald	Courthouse	Crandon
Grant	Sheriff's Office	Erna Mertz	Courthouse	Lancaster
Iowa	Sheriff's Office	Alice Norton	Courthouse	Dodgeville
Jackson	County Nurse's Office	Lila Johnson	Courthouse	Black River Falls
Juneau	County Nurse's Office	Marian Walters	Courthouse	Mauston
La Crosse	Sheriff's Office	Helen Hanson	Courthouse	La Crosse
Langlade	Sheriff's Office	Marjorie Conway	Courthouse	Antigo
Marathon	County Health Unit Office	Cecilia Giesing	Courthouse Annex	Wausau
Marinette	County Nurse's Office	Eleanor Smith	County Normal	Marinette
Monroe	St. Mary's Hospital, Sparta	Florence Finger	City Hall	Sparta
Oconto	Sheriff's Office	Mary Norton	Courthouse	Oconto
Oconto	Sheriff's Office	Mary Norton	Courthouse	Oconto
Oneida	Sheriff's Office	Marian Hill	Courthouse	Rhinelander
Pepin	County Nurse's Office	Esther Wilson	Courthouse	Durand
Polk	(not decided)	Valerie Drew	Courthouse	Balsam Lake
Portage	County Nurse's Office	Mrs. Ruth Gilfry	Courthouse	Stevens Point
Price	Sheriff's Office	Cecelia Coveny	Courthouse	Phillips
Rock	County Health Unit Office	Ida Knutson	Courthouse	Janesville
Sauk	County Nurse's Office	Loella Karow	Courthouse	Baraboo
Shawano	Sheriff's Office	Laura Gollnick	Courthouse	Shawano
Trempealeau	County Nurse's Office	Kathryn Rice	Courthouse	Whitehall
Vernon	Viroqua Hospital	Johanna Frauenfelder	County Normal	Viroqua
Vernon	Hillsboro Hospital	Johanna Frauenfelder	County Normal	Viroqua
Vilas	Sheriff's Office	Catherine Sundstrom	Courthouse	Eagle River
Waushara	County Nurse's Office	Bertha Stephens	County Normal	Wautoma
Winnebago	Oshkosh V. N. A. Office	Ruth Lutz	Algoma Building	Oshkosh

5 incubators not yet assigned.

The Journal Bookshelf

BOOKS RECEIVED FOR REVIEW

The Poison Trail. By William F. Boos, M.D., Boston: Hale, Cushman & Flint, 1939.

Neoplastic Diseases. By James Ewing, A.M., M.D., Sc.D., LL.D., professor of oncology at Cornell University Medical College, New York City; consulting pathologist, Memorial Hospital. Ed. 4, revised and enlarged. Cloth. Price, $14. Pp. 1160 with 581 illustrations. Philadelphia: W. B. Saunders Company, 1940.

The March of Medicine. Number IV of the New York Academy of Medicine, Lectures to the Laity. By Malcolm Goodridge, M.D.; Walter C. Alvarez, M.D.; S. V. Larkey, M.D.; C. K. Drinker, M.D., Sc.D.; Charles G. Heyd, M.D., F.A.C.S., D.Sc.; R. G. Hoskins, M.D., Ph.D.; and Karl A. Menninger, M.D. Cloth. Price, $2. Pp. 168. Morningside Heights, New York: Columbia University Press, 1940.

Psychiatry for Nurses. By Louis J. Karnosh, B.S., Sc.D., M.D., associate clinical professor of nervous diseases, School of Medicine, Western Reserve University; director of neuropsychiatry, City Hospital, Cleveland; consulting neuropsychiatrist, Cleveland Clinic. In collaboration with Edith B. Gage, R.N., supervisor, neuropsychiatric division, City Hospital, Cleveland. Cloth. Price, $2.75. Pp. 327, illustrated. St. Louis: The C. V. Mosby Company, 1940.

Operative Surgery. By J. Shelton Horsley, M.D., LL.D., F.A.C.S., attending surgeon, St. Elizabeth's Hospital, Richmond, Va., and Isaac A. Bigger, M.D., professor of surgery, Medical College of Virginia, surgeon-in-chief, Medical College of Virginia Hospital, Richmond, Va. With contributions by Drs. C. C. Coleman, John S. Horsley, Jr., Austin I. Dodson and Donald M. Faulkner, of Richmond. Ed. 5. Cloth. Price, $18. In 2 volumes, pp. 1567, illustrated. St. Louis: The C. V. Mosby Company, 1940.

Handbook of Hearing Aids. By A. F. Niemoeller, A.B., M.A., B.S. With a foreword by Harold Hays, M.D., F.A.C.S. Cloth. Price, $3. Pp. 156. New York: Harvest House, 1940.

Physical Therapy for Nurses. By Richard Kovacs, M.D., clinical professor and director of physical therapy, New York Polyclinic Medical School and Hospital; attending physical therapist, Manhattan State, Harlem Valley State and West Side Hospitals, New York City. Ed. 2, enlarged and revised. Cloth. Price, $3.25. Pp. 335, illustrated with 99 engravings. Philadelphia: Lea & Febiger, 1940.

Complete Guide for the Deafened. By A. F. Niemoeller, A.B., M.A., B.S. With a foreword by Harold Hays, M.D., F.A.C.S. Cloth. Price, $3. Pp. 256. New York: Harvest House, 1940.

Minor Surgery. By Frederick Christopher, S.B., M.D., F.A.C.S., associate professor of surgery at

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*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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additions. The pages have been increased by twenty-five over the 1936 edition; the 697 illustrations remain the same. By their frequency, large size and distinctness, the illustrations lend desirable morphological support to the general physiological approach used in the written matter.

A division of the material into general and special pathology, used rather frequently in other texts, Dr. MacCallum has never seen fit to make. While the lack of such division has the advantage of avoiding repetition, nevertheless it necessitates considerable reference effort if approaching the subject from the standpoint of the organ involved; the various pathological lesions affecting the meninges, for example, must be searched for under various disease headings in various chapters.

The readable, informal, "lecture" style has always recommended the book particularly to medical students. The paper, printing, and binding continue to be excellent. Among the small but increasing number of American textbooks of pathology MacCallum's continues to hold a place of preeminence. M. B.

Clinical Heart Disease. By Samuel A. Levine, M.D., F.A.C.P., assistant professor of medicine, Harvard Medical School; senior associate in medicine, Peter Bent Brigham Hospital, Boston; consultant cardiologist, Newton Hospital; physician, New England Baptist Hospital, Boston. Ed. 2. Cloth. Price, $6. Pp. 495 with 109 illustrations. Philadelphia: W. B. Saunders Company, 1940.

The second edition of this book, like the first, is a good review of heart disease and is, as the author says, "a personal or individualistic treatise." A new chapter titled "Medicolegal Aspects of Heart Disease" has been added and is worthwhile. The general therapeutic principles are retained and oxygen in the treatment of decompensation is now briefly mentioned. The chapter on clinical electrocardiography includes the standardized precordial lead and is, on the whole, especially good.

This well written, easily read book is recommended to all practitioners of medicine because of its well correlated clinical, laboratory and psychological aspects of heart disease. H. H. S.

The Compleat Pediatrician. By W. C. Davison, professor of pediatrics, Duke University School of Medicine; formerly acting pediatrician in charge, The Johns Hopkins Hospital, Baltimore, Md. Cloth. Price, $3.75, for cash; $4 on credit. Pp. 256 and index. Durham, N. C.: The Seeman Printery for the Duke University Press, 1940.

The new edition of The Compleat Pediatrician is welcomed with the same enthusiastic reception accorded the two previous editions. To those familiar with the book it is only necessary to say that it has been brought up-to-date by the addition of new material gathered during the past three years. The insertion of this added information has resulted in a revision of 10,000 lines. To those unacquainted with the book it should be said that The Compleat Pediatrician is a relatively small, sturdily bound book of 256 pages containing an extraordinary amount of practical pediatric information. As a source of common and unusual facts collected under one cover it has no equal in pediatric literature. All aspects of the general subject of pediatrics are considered, the subject matter being presented in concise but comprehensive statements of fact. For example, the discussion of the drug treatment of epilepsy completely reviews all of the essential information in about 275 words, and of the common problems and disorders of adolescence in about 800 words. A unique feature of the arrangement of the subject matter is the numbering of general headings (250 in all) which permits back and forth reference to related items, thereby expanding the breadth of coverage of any subject under consideration. As stated in the review of the second edition, The Compleat Pediatrician is indeed a remarkable book and one that any physician whose work includes pediatric practice cannot afford to be without. J. E. G.

(Continued on page 572)

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BOOK REVIEWS—Continued

An Anatomical Analysis of Sports. By Gertrude Hawley, M.A., formerly in charge of physical education for women at Northwestern and Stanford Universities; author of The Kinesiology of Corrective Exercise. Cloth. Price, $3. Pp. 191, illustrated. New York: A. S. Barnes & Company, 1940.

Kinesiology may be defined as the science of movement considered especially as a therapeutic or hygienic agency. With this concept in mind, Hawley presents *An Anatomical Analysis of Sports.* It is her belief that the hazards of sport can be minimized and fitness for work enhanced without detracting from the primarily recreational objectives of sport participation. She proposes to achieve this well balanced aim by calling upon the basic sciences to act as yardsticks in the evolution of sports technics. Although she considers anatomy, physiology, chemistry and physics vital to the study of man in motion, the book is almost exclusively an anatomical analysis of sport technics as the title indicates.

It is to be regretted that the rich historical background to this branch of applied physiology is neglected. The sound objectives of the book, as expressed in the preface, might have been more adequately attained if the concepts embodied had been superimposed upon the fundamental work of the nineteenth century investigators like the brothers Weber, Fick, Meyer, Braune and Fischer. The chronophotographs of Marey made a half century ago are in many respects more suitable for the analysis of cycles of movement than the illustrations contained in the book. F. A. H.

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SUPREME COURT DECISION ON OPTOMETRY

(Continued from page 533)

purpose. The true use of the revisor's services is to simplify and make plain the language of the statute. This is to be accomplished with careful and discriminating effort by which changes made are of arrangement and verbiage and to withdraw from the statutes and strike out temporary provisions. A revisor's bill does not change the law, unless the language used indicates that intention so clearly and explicitly that there is no room for interpretation. *Wisconsin Power & Light Co. v. Beloit,* 215 Wis. 438, 254 N. W. 119; *Muldowney v. McCoy Hotel Co.,* 223 Wis. 62, 269 N. W. 655. There was in the revisor's bill no amendment of the substance of the statute.

Respondent's argument that corporations are not allowed to practice a profession by the employment of licensed operators is, in this case, under the infirmity that the kind and character of "profession" practiced by a corporation in employing skilled people is not prohibited. *Golding v. Schubach Optical Co.,* 93 Utah 32, 70 Pac. (2d) 871. Optometry is readily distinguished from a profession in the practice of which diseases of the eye are treated. It is a mechanical art requiring skill and knowledge of the use of instruments designed to measure and record the errors and deviations from the normal found in the human eye. Although certain standards of education are prescribed by the statute, optometry is not a part of the practice of medicine. *Silver v. Lansburgh and Bro.* U. S. Court of Appeals of the District of Columbia. (Decided March 25, 1940.) An optometrist can be an employe. *Tetting v. Hotel Pfister, Inc.,* 221 Wis. 141, 266 N. W. 249; 1 Restatement, Agency, p. 494, Sec. 223. Our legislature has dealt with optometry as a skilled calling, not as a profession involving a relation of special confidence between practitioner and patient. There has been no attempt to classify optometry so as to prevent the engagement of optometrists by "anyone," including a "person, firm or corporation" to assist in a business in which such a calling is naturally an accompanying factor. The point is attempted to be made that appellant is violating sec. 153.01, Stats., which reads:

> "The furnishing, using or employment of any means, device or machine designed or calculated to aid any person in the selection or fitting of spectacles or eyeglasses . . . shall constitute the practice of optometry."

To hold defendant not entitled to employ optometrists and to be guilty of practicing optometry under that section would be to fail to give effect to the obvious purpose of the chapter as a whole. *Wisconsin Industrial School for Girls v. Clark Co.,* 103 Wis. 651, 79 N. W. 422.

We agree with the observation made in the Silver case, supra, where the U. S. Court of Appeals of the

District of Columbia said: "We have considered the cases and are of the opinion the best considered adopt the view that optometry is not 'one of the learned professions.'"

The purpose of the legislation is to protect the public against practice by unqualified persons, and to have optometrists who are able to measure defects of the eye and to adapt the light waves which enter the eye in accordance with optical principles so as to produce focused and single vision with the least abnormal exertion on the part of the eye. Harrington's History of Optometry (1929) p. 24; *State v. Price*, 168 Wis. 603, 171 N. W. 77.

In respondent's brief emphasis has been placed upon the use in the statute of the words "unprofessional conduct." Phrases work themselves into statutes and literature upon a subject because they become convenient in the meeting of situations requiring description, but they cannot be considered of such strength or importance as to carry a meaning contrary to the general import of the statute. A duly registered and licensed optometrist who does not comply with the law would properly enough lose his license. The phrase does not go beyond that. We note that in secs. 153.06 (4) and 153.08, Stats., there is provision made for the discipline of an employer as well as an employe when there is a failure to comply with the statutes. It is there provided that where an employer violates any of the provisions of the chapter regulating optometry, an optometrist cannot remain in his employ and retain his license. If the legislature sought to regulate the employment of optometrists, it must have intended that there be such employment.

The purpose of the statute to insure competent service to the public may be fully accomplished although the optometrist rendering the service is an employe of a corporation. It is considered that the long continued practice of corporations in employing licensed optometrists to test eyes of customers, is not a violation of the law regulating the practice of optometry.

By the Court: Judgment reversed, and cause remanded with directions to dismiss the complaint.

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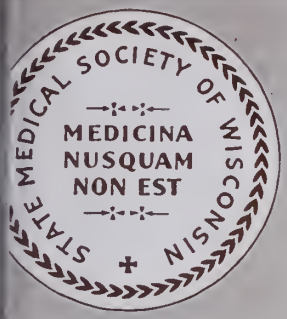

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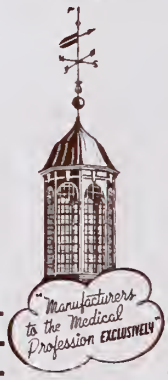

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The Clinical Manifestations of Riboflavin Deficiency

THE most prominent lesion of riboflavin deficiency is a cheilitis characterized by reddening of the lips due to exfoliation of the epithelium, and radiating fissures at the angles of the mouth. There may also be seborrheic lesions in the nasolabial fold and on the alae nasi. According to Krause, Sydenstricker, Sebrell, and Cleckley, riboflavin deficiency produces a magenta color of the tongue. As stated by these investigators, when riboflavin and nicotinic acid deficiencies occur in the same individual, the fiery red tongue of pellagra may change under the influence of nicotinic acid to a magenta color which disappears only after riboflavin therapy.

UPJOHN

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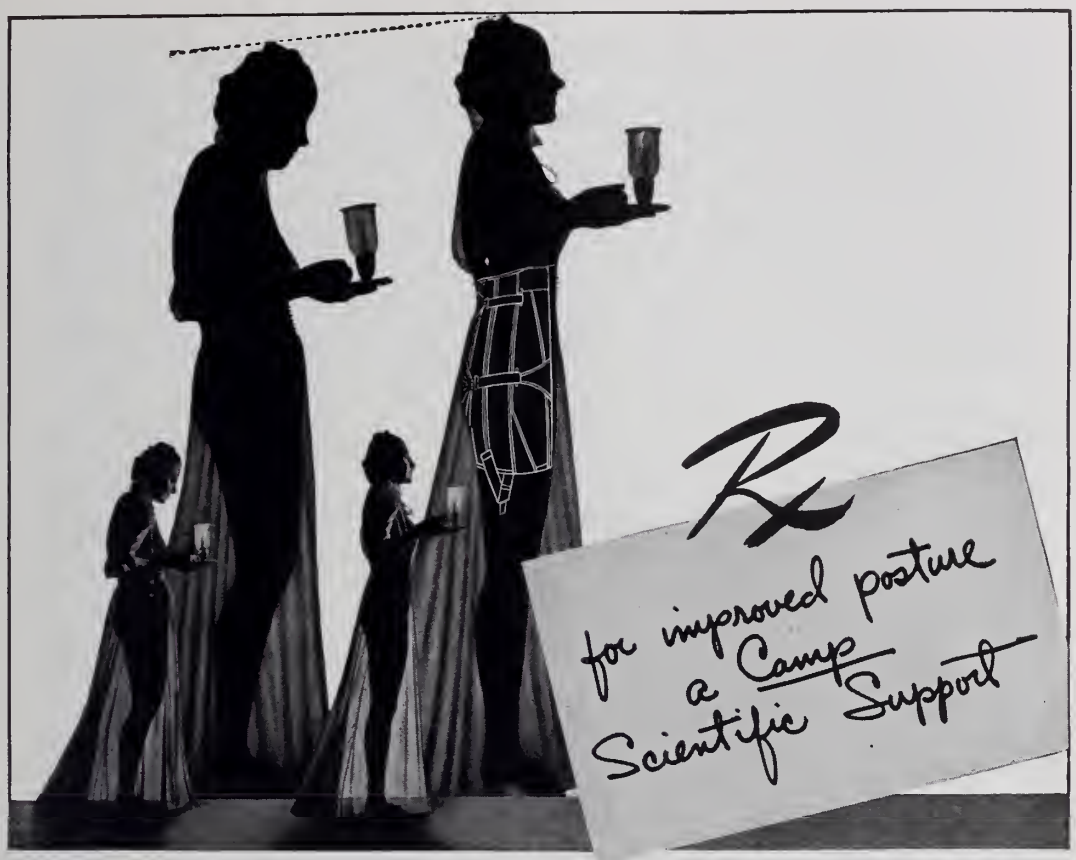

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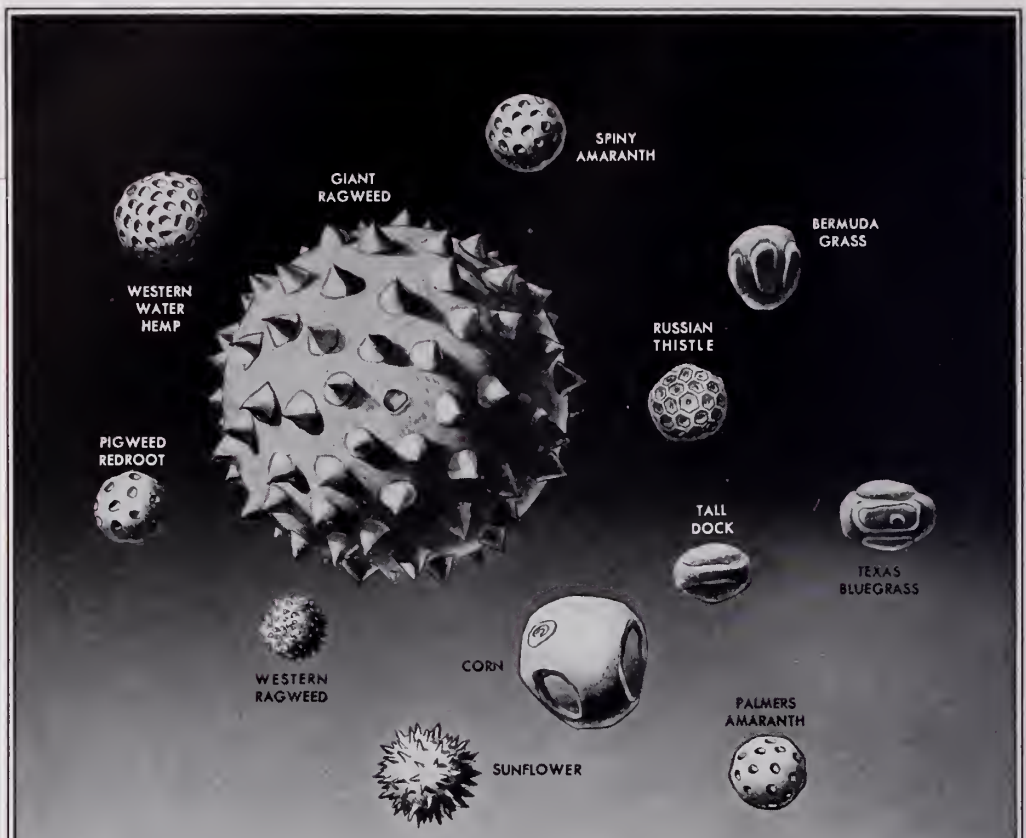

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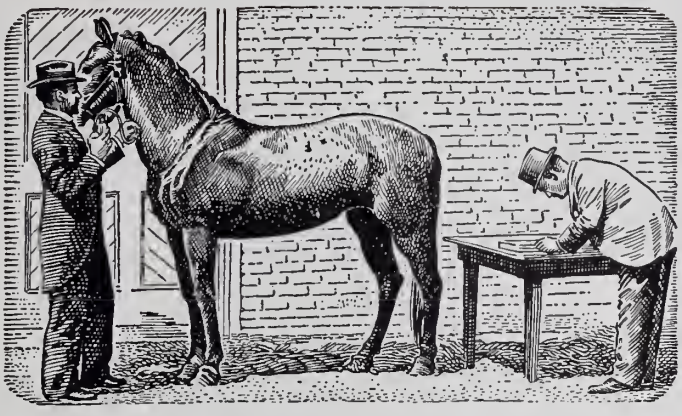

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Recognition and Management of Gastrointestinal Allergy*

By THEODORE L. SQUIER, M. D.
Milwaukee

GASTROINTESTINAL allergy may be defined as the response by the sensitized cells of the gastrointestinal tract to specific antigenic substances. While ingestion of food is most commonly the cause of symptoms, gastrointestinal reactions may also be produced by inhalation or injection of antigens. Food allergy and gastrointestinal allergy are, therefore, not synonymous. Symptoms such as rhinitis, asthma or urticaria may be produced by allergic reactions to foods without any accompanying gastrointestinal manifestations and, conversely, gastrointestinal allergic symptoms may be observed at times as part of the reaction following contact with inhalant allergens such as pollens, animal hairs, etc. Furthermore, some general reactions following injection of antigens in treatment are accompanied by pronounced gastrointestinal allergic symptoms.

Classification and Diagnosis

Patients with gastrointestinal allergy may be divided into two main groups. The first group comprises those in whom ingestion of even minute amounts of a food not commonly included in the diet is promptly followed by acute and violent digestive distress. Such patients have been called "minor allergics" by Vaughan, not because the acute symptoms are themselves minor in any sense, but because the food responsible for symptoms is readily recognized and avoided. No major diagnostic problem arises, therefore, as is the case with the "major allergics" comprising the second group. These latter patients are sensitive to foods taken regularly, such as wheat, milk or eggs. Because of constant contact, self-recognition of the relationship between food ingestion and symptoms is almost impossible and consequently one food after another is apt to be suspected. Indigestion, manifested in varying degrees from mild flatulence to acute crises of abdominal colic, is present but, because after exhaustive study, no objective physical signs of organic disease are found, such patients are frequently labeled "gastrointestinal neurotics." (No one can question the profound influence that emotional factors have on gastrointestinal motility and all digestive functions, and it is true that there is a group of gastrointestinal invalids in whom no other explanation for symptoms can be found than psychic and emotional stress.) Frequently repeated abdominal operations have been done without relief, and all too often the foods which the patient is sure produce symptoms and which have been avoided are so numerous that disturbances due to dietary deficiencies complicate the picture.

Many physicians still are reluctant to recognize that basic items of diet such as wheat, milk or eggs can be responsible for symptoms, and hospital dietitians likewise often look upon elimination of such foods as heresy. Appreciation of the difference between the "minor allergic" and "major allergic" and realization that major foods can cause symptoms constitute the first step necessary for recognition of gastrointestinal allergy when considering the differential diagnosis in these difficult patients.

The history of associated allergic disorders such as eczema, asthma, hay fever, etc., is helpful in identifying the patient as an allergic individual. Gastrointestinal symptoms may, however, be the sole mani-

* From the department of medicine, Marquette University School of Medicine. Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

festation of allergy. A story of definite food disagreements can sometimes be obtained, but, as already mentioned, usually foods taken frequently are involved. Food dislikes are suggestive and without question in some patients the dislike is associated with an underlying sensitivity and apparent protective avoidance. In other instances the dislikes merely represent whims without any relation to allergic sensitivity.

Rowe has called attention to what he has termed allergic toxemia as a part of food allergy. I have been repeatedly impressed by the somnolence and feeling of tiredness mentioned voluntarily by patients after specific reacting foods have been ingested. Abdominal distress, ranging from vague discomfort to acute colic-like pain, may be present. Distention and a sensation of crowding are frequent. Flatulence and a lingering after-taste following the eating of certain foods, such as cucumbers, radishes, etc., may be due to food allergy, but probably are due much more often to irritant, essential oils contained in the food.

Having admitted the possibility of gastrointestinal allergy, it is essential that the presence of organic disease be excluded. Cholecystitis or malignancy may at times be present in association with frank manifestations of allergy. Vague digestive distress is a frequent manifestation of pulmonary tuberculosis. The gravity of mistakes on these scores needs no further emphasis. A gastrointestinal examination made by a competent roentgenologist is an indispensable first step in the management of gastrointestinal allergy. The chief value lies in the exclusion of organic disease, although occasionally suggestive disturbances in motility are observed, as reported by Eyerman, Rowe, Gay and others. Spastic phenomena occur most frequently. Occasionally, as reported by Gay, shadows apparently due to edema of the mucosa have been seen.

The presence of blood eosinophilia is suggestive, but its absence does not exclude gastrointestinal allergy. Positive skin reactions help in identifying the patient as an "allergic." Unfortunately, in many instances skin tests fail to identify specific offending foods—a fact recognized by all allergists. In food allergy, sensitivity may be present to any of the multiple split proteins arising during the process of digestion rather than to the proteins found in the intact food from which the testing extract is made. It is possibly because of this fact that skin tests with foods are notoriously much less informative than are tests with inhalant allergens. Furthermore, some gastrointestinal reactions may be due to simple irritation or allergic sensitivity to nonprotein constituents of foods, such as essential oils. In spite of the inadequacies mentioned, skin tests when accurately done with potent extracts do give important clues. Basic information thus obtained, combined with information from the history, serves as the starting point for dietary management of gastrointestinal allergy.

Dietary Control

Elimination diets, based on the exclusion of foods known to be frequent offenders, such as wheat, milk, egg, chocolate, orange, etc., or upon restriction to a few kinds of food have been very helpful in some hands. In arranging trial diets consideration must be given to the individual food history and also, for test periods, to the information gained by skin tests. The initial trial diet should consist of foods which are less frequent offenders, which have been negative on skin testing and to which there is no history of present or past disagreements. It is my own practice to observe the clinical reaction and the hematologic response following ingestion of the more important foods such as wheat, milk, egg, etc., as an additional guide in planning the dietary program. I have found that a sharp drop in leukocytes, when associated with a relative and often an absolute rise in cells which are eosinophilic in direct eosin-acetone stain, has provided definite help in diet control. The method used has been described previously and like all laboratory procedures the information gained merely contributes one clue to the whole clinical picture which must be considered.

Statements have been made in the literature that when sensitivity to a food is present a clinical reaction, constant in degree and kind, invariably occurs whenever that

food is taken. Unfortunately, from the standpoint of simplicity in recognition, such is not the case. Avoidance of egg by an egg-sensitive child in the course of years establishes tolerance, so that egg may be taken without symptoms. In the same individual the threshold of tolerance for a given food may fluctuate from time to time. Massive exposure from overeating may break the tolerance to a food which has been established by avoidance just as massive exposure to an inhalant allergen will precipitate acute symptoms. Nonspecific secondary factors such as fatigue, illness, psychic upsets, etc., may lower the tolerance sufficiently so that a food will cause symptoms at one time while at other times it may be taken with impunity. Patients with pollinosis frequently recognize intolerance during the pollen season to certain foods which may be taken without difficulty throughout the rest of the year.

When allergic tolerance is broken, constant recurring clinical symptoms regardless of the site of reaction seem to result in spread of clinical sensitivities to an increasing number of allergens. As specific reactions become more frequent the trigger mechanism requires less and less stimulation until finally many nonspecific irritants can cause symptoms. I have seen patients with undoubted gastrointestinal allergy in whom nonspecific abdominal distress would appear even after a glass of water, just as in more severe asthmatics laughing, exertion or nonspecific irritant fumes of any kind may cause an asthmatic paroxysm. The diagnosis and management of allergy in these advanced stages of irritability are difficult. Obviously the immediate effects of elimination diets in this group of patients are not clear-cut nor is it to be expected that relief in the more complicated and chronic cases can be effected without long-continued, painstaking management together with general common sense hygienic measures.

Case Report

One case history will serve to illustrate many of the features of gastrointestinal allergy which I have emphasized.

A 35 year old woman, had flexural eczema in infancy and occasional attacks of urticaria. As a child she disliked milk and avoided it, although cream, ice cream and cream sauces were taken without difficulty. About one year prior to the onset of symptoms she had been advised to drink two glasses of milk daily which she had done without obvious reaction. In the fall of 1935 cream of mushroom soup was eaten at noon and two hours later violent abdominal pain developed, followed rapidly by fever of 103 F., nausea, vomiting, diarrhea and peripheral collapse. By morning all these acute symptoms had subsided. Three others ate corresponding portions of the soup without the slightest suggestion of discomfort.

Following this acute episode she began to have recurrent severe mid epigastric pain usually coming thirty minutes to an hour after meals, and often severe enough to interfere with usual activities. After constant recurrence of symptoms for a period of approximately two months, and negative findings on examination, including gastrointestinal x-ray studies, milk sensitivity was suspected because of the history given. Skin tests with foods were negative. Milk ingestion was followed by a positive hematologic response and characteristic abdominal pain which developed within thirty minutes and continued until forty-five minutes later when she was given ⅜ grain of ephedrine by mouth with prompt subsidence of symptoms. Milk was eliminated from her diet and in the three years that have elapsed there has been no recurrence of abdominal pain.

It is probable that in childhood milk sensitivity was present but dislike of milk and the resulting avoidance established a satisfactory tolerance. After a period of forced milk ingestion an acute gastrointestinal allergic upset completed the break in milk tolerance but because milk in some form was taken at every meal the patient was unable to recognize any relation between the pain and specific foods.

If the etiologic relationship of milk to the pain had continued to be unrecognized in this patient it is not improbable that the clinical picture after a lapse of a few months or years would be typically that classified as "gastrointestinal neurosis."

Self-Elimination of Foods

Because of the constant recurring pain, self-elimination of first one food after another is tried by such patients until almost all foods are suspected. In addition to the distress caused by the specific allergic reactions, undernutrition and vitamin deficiencies inevitably appear because of the self-imposed avoidances. Because of constant re-

curring reactions the gastrointestinal tract gradually becomes more and more irritable. New food sensitivities are especially apt to develop because foods are limited to an ever-narrowing group and finally nonspecific irritability becomes so marked that distress follows nonspecific foods as well as specific offenders.

Summary

Symptoms of gastrointestinal allergy may occur as violent reactions to foods eaten infrequently, which are usually easily recognized and avoided. Such patients constitute the "minor allergics" described by Vaughan in contrast to the "major allergics" whose symptoms are usually more constant but much less violent. Since they result from sensitivity to foods eaten daily, such as wheat, milk or egg, recognition of the etiologic relationship is much more difficult.

Skin tests with foods are notoriously unsatisfactory, but, if accurately done with potent extracts, supply some suggestive leads helpful in developing the diet program. Actual clinical trial of foods under controlled conditions is the only method by which offending foods can be identified conclusively.

Awareness of gastrointestinal allergy and recognition of the fact that major items of diet can produce symptoms will lead to etiologic diagnosis and relief in a number of patients now classed as "gastrointestinal neurotics." Intelligent management will prevent the advanced intractable conditions in which nutritional deficiencies seriously complicate the problem.

DISCUSSION

Frederick W. Madison, M.D., Milwaukee: We are deeply indebted to Dr. Squier and his fellow allergists for the extremely important contributions which they have made to the clinical recognition and treatment of gastrointestinal allergy.

With the knowledge and methods of study which are now available to us, we may not only recognize and diagnose the clinical manifestations of gastrointestinal allergy but we may also, with the help of the allergists, treat them successfully.

The two major syndromes of gastrointestinal allergy are sufficiently well known to permit accurate description and should no longer be confused with other gastrointestinal syndromes. As Dr. Squier has indicated, the allergist calls these two syndromes by the names *minor* and *major*. From a diagnostic standpoint they may well be called *acute* and *chronic*, the acute being synonymous with the minor and the chronic with the major.

Acute gastrointestinal allergy occurs almost entirely in the individual who has "minor" allergies and is a well-defined clinical entity which should never cause great diagnostic difficulty. This individual is one who is usually healthy and well but who, at irregular intervals, suddenly becomes acutely, and, often, rather violently ill. The illness usually follows rather promptly after eating and is often ushered in by swelling of the tongue, scattered urticariae spots and an uncomfortable sensation in the throat. There follows rather rapidly severe epigastric pain, nausea and often vomiting which may be repeated. In a few hours the distress shifts to the lower abdomen and gradually diminishes, to be followed by a diarrhea in twelve to twenty-four hours and a return to normal usually by the end of forty-eight hours. Examination of these individuals shows them to be acutely distressed with little or no fever but with marked pallor, tenderness and at times almost rigidity over the upper abdomen. They will usually volunteer the information that they have eaten something that they know does not agree with them and will usually be able to tell you the foods, drugs or other allergens to which they are sensitive. Differential diagnosis is usually not difficult but must include consideration of the other upper abdominal crises —biliary colic, perforated ulcer, acute pancreatitis and coronary occlusion. Rarely does appendicitis attain such violence in the upper abdomen.

Chronic or major gastrointestinal allergy is much more difficult both from the standpoint of recognition and from the standpoint of treatment. These individuals are usually chronically unwell—"grunters" as a young patient once said—and have been as long as they can remember. They are apt to be difficult, disagreeable and often unhappy people. More than that, they will usually tell you that other members of their families are "grunters." They have usually consulted all manner of healers, regular and otherwise, and often have a well scarred abdomen. Their description of their symptoms may show a wide variation, but two manifestations are almost invariably present: first, they are always most uncomfortable soon after they have taken food, have a dislike for meals of any sort, and, as a result, are apt to be thin, ptotic, underdeveloped individuals; second, their discomfort is always at its worst when they are under strain and least when they are visiting or vacationing. The symptoms usually include bad breath, bad taste in the mouth, "sour stomach," vague discomfort in the abdomen with occasional acute exacerbations, nausea, flatulence—both gastric and intestinal—with the symptoms that go with it, periods of unexplained diarrhea and at times "mucous colitis."

Physical examination is always negative except for occasional tenderness over the descending bowel and perhaps a distended cecum which may or may not be tender. X-ray examination is usually negative though it may reveal pylorospasm, increased gastric activity or spasm of the lower bowel. Differential diagnosis is often difficult. Only x-ray study can be relied upon for final differentiation from gastric or duodenal ulcer, gallbladder or renal disease. Differentiation of interval appendicitis may at times be impossible except by removal of the appendix. The only successful method of therapy is careful allergic study and control conducted by a thoroughly competent allergist, and even this is a long, difficult, and, at times, thankless job. A solution of the problems of these individuals will relieve them of discomfort—the chronicity and extent of which we find it very difficult to appreciate, of anxiety and fear of serious disease, of great medical expense, and only too often of unsuccessful surgery.

Experience With Immunization Procedures in Home and Office Practice*

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IN THE practice of one who cares for children there is nothing more important than preventive immunizations. I will therefore attempt to review briefly those things in this field which seem of practical use, including some of the changes, recent additions and improvements that are occurring so rapidly. The report of the committee on immunization of the American Academy of Pediatrics published in June, 1939,[1] summarizes concisely the conservative recommendations of this group.†

By our inertia those of us in private practice are blocking the effectiveness of immunization. We are failing to utilize what we have available for the prevention of disease in the infants and children entrusted to our care. The number of those immunized against the common contagious diseases for which we admittedly have satisfactory preventive measures, ranges in most parts of the United States from 2 to 50 per cent. In a few localized regions it ranges higher, even above 90 per cent for diphtheria and smallpox, but this is the exception. We may well ask ourselves how much worse the general percentage might be were it not for the activities of health departments which we so often criticize for aggressiveness.

Those who reach the age, nonimmunized, at which they are of interest to most health departments, represent failures in the efficiency of the private practice of medicine. The late Dr. W. H. Park of New York City once said that it is in the very young that immunizations are most needed and in whom they cause the least reactions. Statistics need not be presented to convince us that most of the deaths from contagious diseases and their complications occur during the first three years of life,—we know this from experience. Emerson in reporting the fatality rate for whooping cough in large cities stated that, for each 100,000 of population, 160 infants under 1 year of age died annually; seventy-eight per 100,000 died during the second year; and less than 1 per 100,000 died after the fifth year. M. de Biehler[2] reporting on contagion in Europe said that measles in infancy has a mortality rate ten times higher than that of measles for any other age period, and in addition has four times as many complications.

Factors in Effective Immunization

Effective immunization in office practice hinges on several factors. These include: an understanding of the needs; well refrigerated biologicals and an acceptable plan and technic in administering them; and a planned discussion with all parents having children under our care, explaining the situation and the needs clearly.

Inadequate refrigeration promotes deterioration and loss of effectiveness of most biologicals and increases the likelihood of bacterial growth. An office refrigerator is a need well worth the investment required. It is equally important to know that the druggist from whom we get our supplies likewise has adequate refrigeration and does not merely keep biologicals in a "cool place." There is too much inadequate refrigeration by druggists throughout the state. For those of us who administer some of our immunizations in the home, a small thermos bottle is desirable. Biologicals should *not* be carried around in a warm bag all day.

A discussion with the parents of the immunization needs should be held before the infant is 7 months old. Most parents want to know about disease prevention and appreciate an outlined plan explaining what immunizations should be done, when they should be done, and why. No less important

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* Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

† These recommendations still effective as of May, 1940. Verified by written communication from a member of the Committee.

is an adequate explanation of the nature of the procedures, the reactions to be expected and the efficiency and duration of the protection. Most of the objections that have kept parents from broaching the subject themselves are easily and satisfactorily answered. It is important that the insufficiencies and limitations of each procedure be clearly explained beyond question. One unexpected reaction or failure may be sufficient to block in a whole community the use of a procedure that is ordinarily highly efficient. Therefore in not taking the time and patience to make the problems clear we contribute to an unnecessary mortality from the preventable acute contagious diseases.

Certain general considerations should be kept in mind. The expiration dates of products should not be over-stepped. It is wise to write the expiration date on the bottles in addition to that usually stamped on the containing carton. Frequently these outer containers become mixed or destroyed, leaving the age of the product in doubt. Often at the time an injection is due the child may be developing an unsuspected respiratory or other infection for which, if given, the "shot" is blamed. It is wise to ask questions, take the temperature or do a physical examination before giving an immunization if there is doubt concerning the child's condition.

Some thought in avoiding a display of hypodermics and other awe-producing equipment lightens the burden of fear for the timid child. If two or more children are present at one time, treat the brave one first. His behavior decides the policy of the more timid. If both are timid then one should be elsewhere while the other is treated. Anticipation of a small prize, though a form of bribery, still seems highly commendable when it sends the child away, not in panic or disgrace, but proud of his small favor and of the fact that he has been good.

Children having inoculations which may be followed by reactions, such as those sometimes following the administration of scarlet fever toxin, need their day so controlled as to minimize this. An easy day, light foods and abundant fluids reduce reactions. Friday afternoons or Saturdays when the next twenty-four hours may be spent at leisure are the best times to treat school children.

Immunization Technics and Agents

Immunizations and contagious disease modifiers that have a place in office work may be given in the following order:

Whooping cough.—Sauer's vaccine double strength (20,000 million organisms per cc.) is best given at about the seventh month. Sauer[3] has for five years been immunizing groups of infants only a few weeks old, but he is not yet ready to recommend its use at this early age. Doses of 1 cc. for the first injection; 2 cc. for the second; and 2 cc. for the third are given two to three weeks apart. For children over 2 years of age, the third dose should be 2.5 to 3 cc. The doses are given in the arm subcutaneously and not intramuscularly. Immunity develops in three to four months. As near as can be determined 80 to 90 per cent become protected for at least several years. It is recommended that on known exposure one more dose be given to reinforce the protection. The reactions from these injections are usually slight and transient. In the occasional instance where there is fever and discomfort, restrictions and an appropriate dose of salicylates are effective. Vaccines given for the first time to children after they have been exposed or have the disease are usually disappointing and not of proven value. Meader[4] and others have reported convincing results, however, from the use of 10 to 20 cc. of pertussis convalescent serum given intramuscularly within the first week after exposure. The committee on immunization for the American Academy of Pediatrics feels that the value of giving 35 cc. to 50 cc. of convalescent serum has been demonstrated in the active treatment of pertussis.

Diphtheria.—In diphtheria protection it is preferable not to immunize under 8 months of age. Immunity is not well established during the earlier months while the infant still retains some of the passive protection transferred from its mother. One dose of alum precipitate toxoid cannot be relied upon to satisfactorily immunize an

individual. This has been shown by several authors. In a group of children in Chicago given one dose of alum precipitate toxoid, less than 50 per cent had a blood antitoxin content of the desired amount.[5] Two doses, at least, of regular or of alum precipitated toxoid should be given two to four or more weeks apart. Doses of 1 cc. each are satisfactory for younger children. For those over 7 or 8 years of age a smaller amount (0.1 cc. and up) may be given as the first dose. Older children sometimes have reactions from toxoid if it is given in the same dosage as that used for younger children.

A Schick test should be done a few months after immunization, but a negative Schick test does not mean that the child will always remain protected, or that protection is always sufficient to prevent extremely virulent diphtheria. At school age another Schick test should be done or, perhaps better, as recommended by Dr. Schowalter, another dose of toxoid given in place of the Schick test at this time. Approximately 12 per cent of those with negative Schick tests still have considerably less than the 1/25 of a unit of antitoxin per cc. of circulating blood, the amount believed necessary for complete protection.

Tetanus.—The use of tetanus toxoid is mentioned at this time because it is available combined with the diphtheria toxoid. Therefore it may be given without the discomfort of additional injections. It is of proven value and its use has been compulsory in the French armies since 1936. The duration of complete protection is not more than from eight to sixteen months in the average person. Partial protection does exist for a long period so that on exposure for which a dose of tetanus antitoxin would ordinarily be given, an additional dose of the toxoid quickly reinforces the basic immunity. This goes well beyond the 0.1 unit per cc. of serum, the amount considered adequate for protection. Again it is slowly lost in part, but remains adequate for months. Remember that the toxoid contains no serum. Any method of tetanus protection which does away with the necessity for using foreign serum antitoxin as well as with its uncertain and transient protection seems highly justified.

When and when not to give tetanus antitoxin has always been a "headache." Occasionally the decision has meant catastrophe either from withholding it, or from administering it. I know of three cases of tetanus occurring unexpectedly within this region during 1939. Two resulted in fatalities. The third is still ill, but recovering. At the Chicago Children's Memorial Hospital, Dr. John Bigler[6] has for some time been running a controlled series of tetanus immunizations making blood serum titrations for antitoxin content. He is definitely in favor of the use of toxoid as a routine protection for children and will soon publish his work. Dr. Fernan–Nunez, who gave an excellent paper on tetanus before the State Medical Society in 1938,[7] feels at this time even more than before, that the use of toxoid should be routine for children and also for adults subjected to more than the usual possibilities of exposure. Two doses of 1 cc. each of the toxoid are given either combined or without the diphtheria toxoid. For older individuals, the first dose at least should be smaller, just as in giving diphtheria toxoid, because of the greater tendency of older children and adults to toxoid reactions.

Smallpox.—Smallpox vaccination needs little comment except to urge its routine use. There were 420 cases of smallpox reported in Wisconsin alone in 1937 and 1938.

The technic of multiple punctures that has been standard for some years, using the calf vaccine virus, still seems the most desirable. The artificially grown virus given by intracutaneous technic, and other changes do not seem as yet of any decided advantage in our routine work. An added reason for immunization at a young age in the case of smallpox is that the encephalitis, occasionally reported, does not occur before the age of three years. The need of careful vaccination technic to prevent auto-inoculation to some other area than intended is more important than is realized by those who have not had this unfortunate accident happen.

Scarlet fever.—Because of the controversy that exists about the advisability of actively immunizing against scarlet fever, I hesitate to commit myself. Nevertheless I am convinced that there is a place for it and that

in the majority of instances satisfactory protection can be obtained by the use of scarlet fever toxin without undue reactions. I have used it for a number of years in private practice under favorable conditions, and will certainly continue to do so. In caring for children in an orphanage I have seen no scarlet fever in the last four years since immunizing; previously four to twenty cases of scarlet fever occurred annually. The experience of others caring for institutional children has been in general the same.

Certain restrictions in its use seem wise for obvious reasons. The parents should not be urged in any way, but be told of its disadvantages, the number of injections, the reactions, and the fact that a portion of those immunized will not retain full immunity long. A Dick test should always be done first to be sure that protection is needed. While the Dick test is not as efficient as the Schick test it is in general reliable. It seems wise to delay scarlet fever immunization until after the third year of age. The disease is rare in infancy.[8] Certain children who are panicky about injections may well be left unimmunized. One of the chief objections to doing all these immunization procedures on children is the psychological effect. One must consider differences in their nervous constitutions and be guided accordingly. Occasionally a child will be found who will have severe reactions after one or more of the usual doses. In these instances it is wise either to reduce the dose to tolerance, or discontinue the procedure completely.

The use of scarlet fever immunization in schools and large groups where individualization cannot be had, and where parents may not fully understand the possible reactions, cannot be recommended.

Measles.—While we have no active immunization against measles, the use of human measles convalescent serum, or of whole blood from a person who has had measles, is extremely valuable. Its greatest use is in giving enough to avoid the attack entirely in a young child or in a debilitated child. It has been a life saver in hospitals in children already ill from other disease who have also a known exposure to measles. Partial protection is also desirable for modifying the disease in older well children known to have been exposed to measles. The severe symptoms of harassing cough and the preeruptive stage can be almost entirely eliminated. In the active treatment of severe measles, where of course larger amounts (40–50 cc.) of convalescent serum are needed, it is of value.[9] For modification to complete prevention of measles, 4 to 10 cc. of the convalescent serum are given during the first few days after exposure. This is easily obtained in Wisconsin and easily administered intramuscularly in the office or home. One does not fear reactions; a disease which causes from six to ten thousand deaths a year and the high respiratory morbidity well deserves the protective value that modification by such simple means offers. Much the same may be said about the use of human pooled scarlet fever convalescent serum for the management of scarlet fever.

A permanent office record of all immunizations should be kept. Parents soon forget the diseases for which their children have been immunized. A permanent record form, very satisfactory to parents, is authorized and distributed by the American Academy of Pediatrics, 636 Church St., Evanston, Illinois.

May I conclude by repeating that we have a number of measures for immunization against, and modification of, certain contagious diseases which, if used more routinely and at an earlier age would greatly add to our efficiency in private practice.

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A Pediatric-Urologic Problem*

Congenital Valves of the Posterior Urethra With Case Report

By WALTER M. KEARNS, M. D., and EDWARD B. JACOBSON, M. D.
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THE incidence of anomalies in the urogenital tract is greater than in any other system in the human body. Consequently these anomalies have attained a position of deserved prominence in modern urological literature. They account for much destructive uropathologic disease in young and old alike. Many of these anomalies are incompatible with life and result in intrauterine death; others are the cause of prolonged urinary disorders and life-long suffering.

Valves of the posterior urethra, next to stenosis of the urinary meatus, are the most common cause of congenital infravesical obstruction. They are of extreme clinical importance, producing varying degrees of urinary backpressure. If unrecognized, this anomaly may be the ultimate cause of serious and even fatal changes in the upper portion of the urinary tract.

Synopsis of Literature on Etiology and Incidence

As Hinman[1] states, congenital urethral valves were first described by Langenbeck in 1802, and during the next 110 years twenty additional cases were reported. All of these reports were on autopsy specimens or cases discovered by accident at operation. Hugh H. Young in 1912 described the first case discovered at cystoscopy. This was in a boy 17 years of age who had had urinary difficulty since birth. Death followed one year later from pneumonia, and the original diagnosis was confirmed at necropsy. In 1913, Young removed at operation obstructing congenital valves in a 20-month-old infant with good functional results.

Bugbee and Wollstein[2] in reviewing 4,903 autopsies at the Babies' Hospital in New York, found the incidence of anomalies in the urinary tract in children to be 2.3 per cent. They cite ten occurrences of hypertrophy of the verumontanum, causing urinary obstruction with a resulting hydronephrosis and pyonephrosis. The authors state that valve formations of mucous membrane were the cause of obstruction in several unexplained cases of hydronephrosis and attest to the difficulty of recognizing these valves at necropsy. Meredith Campbell[3] collected 166 cases. Counseller and Menville[4] have reviewed eighty-four cases. Unquestionably congenital posterior urethral valves occur more frequently than the literature would lead us to believe. Many cases go unrecognized and death results from an intercurrent infection. Congenital valves are found in males, from birth to old age. The condition is most frequently observed in the very young (75 per cent before the age of 10 years and 52 per cent before 5 years, according to Counseller and Menville). Iverson[5] reported the finding of the anomaly in a man 85 years of age. Fuchs[6] found congenital valves in a 5-month-old fetus.

The valves are always found in the posterior urethra and bear a definite relationship to the verumontanum. They consist of mucous or fibrous folds, radiating upward or downward from the verule and are attached to it. Absorption of these attachments with fusion of the lateral folds, account for the iris type. Three general types of valves are described: (1) supramontane, (2) inframontane, (3) iris. (Fig. 1.) They balloon out during urination in cusp formation and produce obstruction. Valves sometimes occur as unilateral formations with the opposite side of the urethra normal.

The definite etiology is unknown, and of the theories advanced, that of Tolmatschew[7] is the most acceptable. He attributes the presence of the valves to the enlargement or hypertrophy of the normal urethral folds. Bazy[8] believes they represent the persistence of the urogenital membrane; Lowsley[9] considers them as anomalous Wolffian or Müllerian duct developments; and Watson[10] considers the formation of the valves a result of the fusion of the colliculus with the posterior urethral roof.

Symptoms and Diagnosis

The symptoms are: (1) disturbance in urination which may range from frequency and dysuria to a complete retention (dribbling, enuresis and paradoxical incontinence may be present); (2) renal impairment with its accompanying gastric and neurologi-

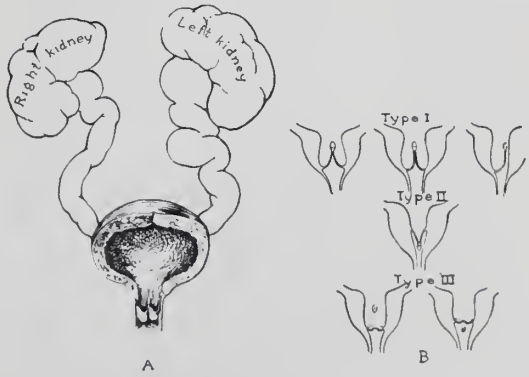

Fig. 1. Three types of congenital valves of the posterior urethra. A. Inframontane type (after Beck). B. Type I, inframontane; type II, supramontane; and type III, iris (after Young).

* Presented at the joint meeting of the Wisconsin and Twin Cities (Minnesota) Urological Societies at Eau Claire, Wisconsin, May 12, 1939.

cal symptoms; (3) infection as manifested by pyuria, chills and temperature reactions. The clinical picture is clear-cut and strongly suggestive, but other obstructive lesions must not be overlooked.

Occasionally there are no urinary symptoms present and the entire clinical picture is suggestive of disease of the gastrointestinal tract. Kretschmer and Pierson[11] cite such a patient in whom an operation was performed for pyloric stenosis because of intractable vomiting. Death occurred two days later and the findings at necropsy confirmed the actual diagnosis of valves of the posterior urethra with dilatation and massive destruction of the upper urinary tract.

The diagnosis is suggested by the complaint of life-long urinary difficulty and can be readily confirmed by modern urological diagnostic methods. Cystoscopic and urethroscopic diagnosis has been made possible by the improved instruments. The valves can be clearly demonstrated by changing the position of the instrument in the urethra and regulation of the irrigating water flow. Cysto-urethrograms aid in making an accurate diagnosis. With definite valvular obstruction, signs of dilatation of the urological structures above the obstructing point can be demonstrated. The prostatic urethra is dilated, and the internal vesical sphincter opened. This gives a picture of a funnel-shaped vesical neck and must be differentiated from a similar condition resulting from a cord bladder with paralysis.

Diverticula of the bladder sometimes accompany the condition. Campbell[3] reports the incidence of diverticula in 3 per cent of his series. Recently Day and Martin[12] in a discussion of bladder diverticula, cite the presence of a diverticulum in a boy, 5½ years of age, with congenital valves in the posterior urethra. They erroneously state that in the available literature this is the only reported instance of bladder diverticulum resulting from congenital urethral valves. Both ureteral valves may be rendered incompetent by the back pressure. In these instances, whenever a cystogram is made, a retrograde pyelogram also results because of ureteral reflux.

Treatment and Prognosis

Treatment is directed to the relief of the obstruction. Extreme care must be used in the preparation of these patients. The same precautions observed in the examination and treatment of patients with prostatic disease must be taken here. Surgical intervention should "mark time" until kidney function improves. Oftentimes continuous bladder drainage by urethral catheter or cystostomy drainage is the only safe therapeutic procedure. Bilateral nephrotomy drainage may be indicated when tortuous stenotic hydroureters with hydronephrosis are present. The valves can sometimes be forcefully ruptured by urethral sounds. Suprapubic or perineal approach may be used, but the method preferred is that of transurethral removal of the obstructing valves. This can be accomplished by use of the Young punch, fulguration, or the cutting current. The latter, using the loop electrode through the operating cystoscope, is the method of choice. After the obstructing lesion is removed, attention is directed to the permanent relief of the dilatation and infection of the upper portion of the urinary tract.

The prognosis depends entirely upon the amount of destruction present in the upper part of the urinary tract. Since this condition is congenital, pathological changes begin in the fetus in utero. The fetal kidneys start to function about the fifth month of gestation, and urination necessarily follows. This fact is attested to by the chemical similarity of urine and liquor amnii. Further, in the event of congenital vesical obstruction, the bladder of the infant at birth is overdistended and may result in dystocia.

A complete occlusion of the urethra is incompatible with life unless a patent urachus or an enterovesical fistula exists. The degree of obstruction and back pressure is the governing factor in the amount of dilatation of the upper urinary structures. The ureters may be dilated, elongated and tortuous, and the kidneys hydronephrotic with only a thin shell of secreting substance remaining. A urinary tract so altered by retention and back pressure is ready prey to infection. Infections when they occur are very severe since the immunity is low and resistance is

Fig. 2.

impaired. Death results from uremia or sepsis.

Case Report

A premature (8 months) male infant, weighing four pounds, nine ounces, was delivered spontaneously September 8, 1938. The mother's history was negative. One normal pregnancy preceded the present delivery. The infant was placed in an incubator immediately, and progressed favorably up to the fifth day, when the abdomen appeared distended by an abdominal mass. An enema did not reduce the size of the tumor.

According to the nurse's record, the child had apparently urinated. On careful check it was found that the infant voided very small amounts. Repeated attempts at urethral catheterization by members of the house staff were unsuccessful. A suprapubic puncture of the bladder was performed and 200 cc. of concentrated urine were aspirated, resulting in the complete disappearance of the abdominal mass. Hippuran solution (150 cc. of 20 per cent solution) was reinjected through the aspirating needle and roentgenograms were made (Fig. 2). Fairly satisfactory pictures resulted, identifying the tumor as a distended bladder. A diverticulum was found at about the site of the right ureteral orifice. The internal sphincter appeared relaxed and a funnel-shaped posterior urethra was evident. No vesico-ureteral reflux was seen. An excretory urogram was unsuccessful because of the lack of concentrating ability of the kidneys.

The infant received supportive parenteral injections of glucose, normal saline solution, and whole blood. The bladder was kept drained by repeated bladder paracentesis. On the twelfth day, one of us succeeded in passing a number 5 ureteral catheter, after overcoming a definite obstruction at the level of the verumontanum. The catheter was held in the bladder by adhesive tape and continuous drainage was maintained by irrigation and aspiration. The child's condition became progressively worse, weight loss was evident, and a marked temperature rise occurred. The urine was concentrated and contained numerous bacteria. Death occurred on the sixteenth day from pyelonephritis and uremia.

Postmortem findings corroborated the clinical diagnosis. An air cystogram demonstrated very well the diverticulum and the dilated proximal urethra (Fig. 3). Injection of both kidneys, with opaque medium, indicated the degree of destruction of the kidneys by urinary back-pressure (Fig. 4).

Fig. 3.

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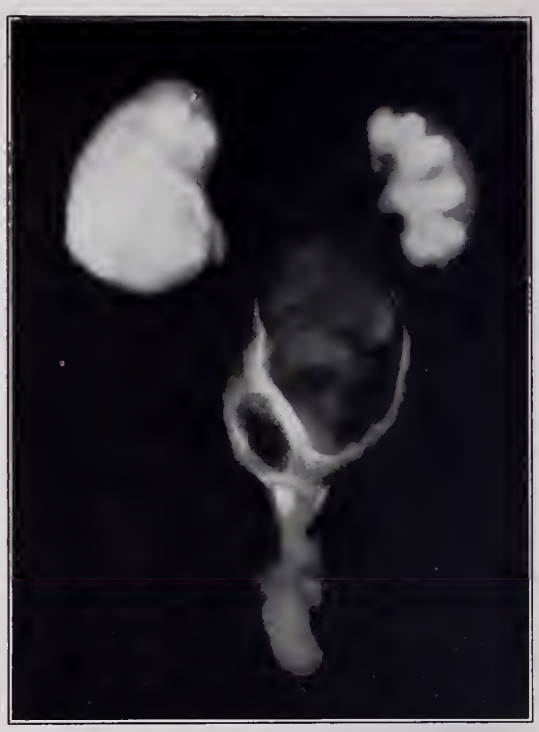

Fig. 4.

Fat-Carbohydrate Ratios of the Diet and Insulin Requirements in Diabetes Mellitus*

By ROBERT S. BALDWIN, M. D.

Marshfield

THE question of the optimum proportion of fat and carbohydrate in the diet is still one of great concern to those who are doing investigative work in diabetes. The literature on the subject is extensive, and excellent discussions may be found in the publications of Cantarow,[1] Joslin,[2] Burr,[3] Ward and Nelson,[4] and Woodyatt.[5]

Those who favor higher carbohydrate and lower fat ratios for patients with diabetes mellitus claim the following advantages for such diets:

1. The patient has a greater sense of well being.
2. Susceptibility to coma is lessened.
3. Susceptibility to infections is lessened.
4. Little, if any, increase in insulin is required.
5. Blood sugar is not increased.
6. There is a tendency to lowered cholesterol in the blood.
7. The patient is less conspicuous in his selection of food.
8. The food is cheaper.
9. Larger amounts of milk can be included in the diet.
10. The patient is less tempted to break his diet.
11. The diet is less bulky.
12. The diet has a favorable effect on cardiovascular conditions.
13. Water is retained in the body when the diet is changed from high fat to high carbohydrate.[6]

They also call attention to the fact that recent work[7] has tended to show that the insulin yield per gram of pancreas is less in

* From the Marshfield Clinic. Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

experimental animals fed on high fat diets than in those fed on high carbohydrate diets.

Those who prescribe high fat diets believe an increase in carbohydrate will necessitate so great an increase in the insulin dose that the advantages of the higher carbohydrate diets are far outweighed.

To determine the reasonableness of these beliefs a study was made of the effects of variations in the fat-carbohydrate ratio on insulin requirements in a group of patients whose diets were changed from low carbohydrate-high fat to higher carbohydrate and lower fat ratios.

Any conclusions drawn from the data presented here must be made with the realization that many factors other than diet influence the patient's ability to metabolize glucose. Some of these factors may be listed as follows:

1. Infections
2. Acidosis
3. Hyperglycemia
4. Insulin
   (a) Type
   (b) Time of administration
5. Emotions
6. Trauma
7. Surgery
8. Other endocrine glands, especially (a) pituitary, (b) adrenal, (c) thyroid
9. Unknown

From a group of 300 patients with diabetes mellitus who have been under my supervision during the last five years thirteen were selected for study. They were chosen because of their experiences with diets of varying fat and carbohydrate composition. The data on these thirteen patients is presented in Tables 1, 2, 3 and 4.

TABLE 1

Case number	Sex	Age	Carbo. Gm.	Fat Gm.	Insulin units†
1	M	73	70	160	28R
			150	100	15R
2	F	31	80	190	45R
			150	100	30P + 5R
3	M	50	90	215	45R
			180	120	35P
4	F	33		*	20P
			120	80	20P
5	F	59		*	20P
			150	100	10R to 20P
6	M	14	70	165	50P
			150	135	50P

† In insulin units noted, R stands for regular insulin, P for protamine zinc insulin.
* High fat diet; exact composition not determined.

TABLE 2

Case number	Sex	Age	Carbo. Gm.	Fat Gm.	Insulin units
7	M	27	80	190	45R
			120	130	50P
8	M	28	95	210	30R
			110	160	35P
9	M	42	90	140	0
			200	100	20R

TABLE 3

Case number	Sex	Age	Carbo. Gm.	Fat Gm.	Insulin units
10	M	8	75	110	16R
			110	75	16R
			125	90	17R
			165	90	22R
11	M	5	70	165	3P
			130	180	37P
			160	135	37P
			180	180	37P
12	M	16		*	46R
			184	160	68P
			240	140	50P
13	F	17	70	160	19R
			135	140	30P
			70	215	30P
			100	190	35P
			140	165	40P + 8R

TABLE 4

Case number	Sex	Age	Carbo. Gm.	Fat Gm.	Insulin units
6	M	14	150	135	50P
			70	165	90P
13	F	17	135	190	30P
			70	215	30P

Comment

The patients are arranged in four groups in order more clearly to show the effects of diet changes on insulin dose.

The first group (table 1) includes six patients who increased the carbohydrate of their diets without finding it necessary to increase the insulin dose. The first three, moreover, were able to lower the dose.

In the second group (table 2) are patients who made increases in the carbohydrate of their diets and were required to increase the insulin dose. The first two patients needed five units more, and the third twenty units more. The diabetes of this last patient was uncontrolled on the high fat diet and he was not using insulin. I am sure his condition would have required just as much insulin for control on the high fat diet as on the high carbohydrate diet.

In the third group (table 3) are four patients who made several changes in their diets:

The first patient (case 10) required no additional insulin after the first change, one more unit after the second, and five additional units for the third change. Thus he required six additional units for a total increase of 90 grams in the carbohydrate of his diet.

The diabetes of the second patient (case 11) was, for several months after the increase in carbohydrate, controlled on the same insulin dose as was needed on the high fat diet. He was then forced to increase the dose by thirty-four units. The loss of tolerance occurred within the period of one or two weeks during which he had acetonuria on numerous occasions, apparently because of an attack of nasopharyngitis. After recovering from his cold the insulin dose during the next month fluctuated from thirty-seven to twelve units and finally remained at thirty-seven units. Since then his carbohydrate has been increased by 30 grams and later by 20 grams without any increases in the insulin dose.

The third patient (case 12) ultimately required four units more on his high carbohydrate diet than he did on his original high fat diet. During the months while the changes were being made his insulin requirement rose and fell several times, once to twenty-two units above the dose for the high fat diet, and once to fifteen units below it, finally to settle at a level four units above that of the high fat diet. The changes in insulin need occurred rather suddenly. We were unable to discover any cause for them.

The fourth patient (case 13), after the first diet alteration, was able to control her glycosuria for several weeks with one unit less; but, later, after changing to protamine insulin she was forced to add eleven units. After the second increase in carbohydrate, five units were added, but, after the third increase, thirteen units were added. Thus she ultimately required twenty-nine units more on her last higher carbohydrate diet than she did on the original high fat diet, and eighteen units more than she used while on the second high fat diet.

In the fourth group (table 4) are two patients who were put back on high fat diets after having been on higher carbohydrate diets. In case 6, previously included in table 1, a forty unit increase in the insulin dose was required after going back to the high fat diet. In case 13, previously included in table 3, the same amount of insulin was required on one diet as on the other.

Summary

These thirteen patients had twenty changes made in their diets in the form of increases in the carbohydrate content, with decreases, in most instances, in the fat content.

In eleven instances the insulin dose remained the same or was lowered. Three patients (cases 1, 2, 3) were able to lower their insulin doses by ten or more units after the changes in the diets. One patient (case 12) initially found it necessary to increase his insulin dose by twenty-two units, but later was able to reduce it by thirty-eight units, and control his diabetes for several months with this lower dose. Subsequently, however, he found it necessary to add twenty units so that ultimately his insulin requirement was four units more on the high carbohydrate diet than it was on the original high fat diet.

In four instances (cases 7, 8, 10, 13) the insulin doses were five units higher after diet changes were made.

In five instances (cases 9, 11, 12, and twice in 13), increases of from thirteen to thirty-four units were necessitated by the diet change. Included in this group is one patient (case 9) whose glycosuria was uncontrolled on the high fat diet at the time the change was made and undoubtedly would have required just as much insulin on a high fat diet as was needed for the high carbohydrate diet. Also included in this group is the patient (case 12) who initially increased his insulin by twenty-two units after the change but who ultimately needed only four units more.

In two instances (cases 6, 13) patients were later put back on high fat diets. In the first (case 6) the insulin dose was forty units higher on the high fat diet than it had been on the high carbohydrate diet. In the second (case 13) the insulin dose was the same on the high fat diet as it had been on the high carbohydrate diet.

Conclusions

1. The carbohydrate-fat ratio of the diet is not rigidly related to the patient's insulin requirement.

2. Many other factors determine the insulin dose.

3. Spontaneous changes in the patient's insulin requirement often occur.

4. A diet which satisfies the patient and keeps his weight at the proper level may be selected without danger of wasting insulin.

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DISCUSSION

Dr. M. M. Baumgartner, M. D., Janesville: Dr. Baldwin clearly demonstrates that a diabetic diet frequently may be adopted which is more to the patient's liking and requirements, without significant changes in insulin dosage. This seems to be particularly true when protamine zinc insulin is used. However, certain fundamental factors in the management of diabetic patients and their disease should not be forgotten. Good treatment necessitates individualization and application of common sense rather than fixed rules, formulas or stock diets. Rules and formulas are valuable in testing the diet after it has been shown to be palatable or in deciding whether it is nutritionally adequate. A diet more liberal in carbohydrate certainly is better appreciated by the patient and makes him less conspicuous, but time alone will tell whether it will lessen the incidence of complications or increase his life expectancy.

The extremely high carbohydrate diets that have been advocated are essentially the same as the diet followed by a normal individual. This means 4 to 5 grams of carbohydrate per kilogram of body weight and one gram or less of fat. Such a diet may contain 275 to 300 grams of carbohydrate, 50 to 80 grams of protein and as little as 40 to 50 grams of fat. I have had no experience with such diets but would expect that glycosuria would be more difficult to control. It seems that, psychologically, if a diet be too liberal, there would be no incentive on the part of the patient to follow it. The effect of the diet is to be judged by following it, not by breaking it. Diet still remains the principle treatment and insulin only an adjunct to control.

The other extreme in diet, the high fat-low carbohydrate diet, provides 2 to 3 grams of fat per kilogram of body weight and but approximately 0.5 gram of carbohydrate. Calculated on the same basis as above, the fat in this type of diet may reach 200 grams, the protein the same, and the carbohydrate merely 40 to 50 grams. This type of diet was claimed to control glycosuria, avoid acidosis and maintain nitrogen equilibrium. But, with the introduction of insulin, the regime in this country has been more and more liberalized until now an intermediate diet is in vogue. Such diets provide about 2 grams of carbohydrate per kilogram of body weight and perhaps 1.5 grams of fat. These diets are very palatable and easy for the patient to follow.

The need for individualizing the diet and avoiding fixed rules or formulas is apparent. The aim in the care of the diabetic patient should be to keep him fit in the general sense and avoid the dreaded complications of acidosis, infection and vascular disease. The relation of arteriosclerosis to diabetes is not a settled one. It seems the disease sometimes is the result of the vascular degeneration rather than the cause. Certainly several generations of diabetic patients must be studied to settle this question and decide whether, if the disease causes coronary thrombosis and gangrene of the legs, the type of diet or insulin or both will lessen their incidence. Beware of sudden radical changes in the diet in longstanding diabetes, for acidosis may be precipitated. Acidosis results from ignorance or neglect on the part of the patient or lack of proper supervision by the physician. The diabetic patient must be taught how to control his disease.

In conclusion, I feel that diets too high in carbohydrate, that is, with too high a glucose value, invite laxity on the part of the patient, which, with the multiple other factors outside our control that affect tolerance, increase the possibility of glycosuria. The usual patient is satisfied physically and is not embarrassed by diets providing from 125 to 150 grams of carbohydrate; 50 to 70 grams of protein; and 100 to 130 grams of fat. And the diabetes is usually controlled, even though severe, with insulin dosage not in excess of one unit per kilogram of body weight. From Dr. Baldwin's paper, it seems that this is the type of diet he has advocated, and he has found it necessary in very few instances to increase the insulin necessary for control. Although the diet is liberal it should be followed strictly. Essentially it will be found to limit foods high in carbohydrate and omit only the complicated types of sweetened foods and desserts, particularly pastries.

Retroposition of the Uterus

An Evaluation of Its Effect Upon Certain Phases and Events of a Woman's Life*

By CARL S. HARPER, M. D.
Madison

RETROPOSITION, including flexion and version, is the most frequent malposition of the uterus. The posterior position may be the result of development, known as the congenital type, or may be acquired as the effect of pregnancy and delivery due to alteration in muscular tone and damage to the uterine supports. It may also be acquired from the pressure and weight of new growths in the fundus or near-by organs; it may result from peritonitis or follow surgical procedures. In order to state that the condition is acquired, one must have knowledge that the uterus was anterior prior to the existence of the causative factor. I believe that most retropositions of the uterus are of the congenital type.

The uterus in the posterior position may be freely movable, may be fixed by pressure, or may be adherent. Retroversions of the congenital variety and those following childbirth are usually freely movable. They may often be replaced anteriorly and maintained by insertion of a pessary, which is a most valuable means of determining the relation of a malposition to the complaint of the patient. New growths may fix the uterus through pressure or adhesions; inflammatory disease, surgical trauma, and endometrial transplants may all produce adhesions. The fixed and adherent group usually present the symptoms and pathologic changes of the causative disease and are treated from the aspect of the disease rather than from the standpoint of the malposed uterus.

This discussion represents my personal views on the relation, primarily, of a movable, retroposed uterus to certain events and phases of the patient's life; and, may I say, first of all, that I have never known a woman to die of posterior position of the uterus without the aid of a surgeon. It is well to keep this point in mind when proposing surgery to the patient.

The pathologic picture in this condition, where pathologic change exists, appears to depend upon disturbance of the circulation, together with loss of muscular tone and uterine support. In a condition of long-standing, there may be increase in size of the uterus, fibrosis, hypertrophy of the endometrium, varicose veins of the broad ligaments, and cystic change in the ovaries.

Before puberty I know of no symptoms referable to retroversion of the uterus. The vascular supply has developed in relation to the position and seldom has cause for alteration. The menses, although they transiently produce congestion of the uterus, are not apt to be affected by retroversion of the uterus until after childbirth. The small uterus, and scanty and painful menses are much more often seen in the uterus that is anteflexed. After childbirth, however, the uterus which becomes, or remains, retroposed is prone to be large, soft, and congested; the menses are more apt to be excessive and painful; there is a bearing-down feeling in the pelvis, and early pessary treatment is advisable.

After marriage, retroposition of the uterus may be an occasional cause of dyspareunia from direct pressure upon the fundus or ovary. Replacement of the uterus and a pessary will usually effect a cure.

Effect on Conception and Pregnancy

Does retroposition affect conception? I have often heard a patient say, "The doctor told me that I could not become pregnant, or carry the child if I did conceive, because the womb is tipped." May I mention here

(Continued on page 690)

* From the department of obstetrics and gynecology, University of Wisconsin Medical School. Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

Comments on Treatment

EDITORS
A. J. Quick M. D., Marquette University, Milwaukee
and
M. H. Seevers, M. D., University of Wisconsin, Madison

Carbon Monoxide Poisoning

Carbon monoxide poisoning is encountered with relative frequency, since it is employed commonly in suicide, and also is responsible for a considerable number of accidental deaths. Illuminating gas is the most common source of carbon monoxide, but it is also contained in motor exhaust fumes, and coal gas leaking from defective stoves, pipes and flues. The diagnosis of poisoning from carbon monoxide is usually fairly simple, especially if the odor of gas is detected at the time the victim is found. Occasionally, however, a correct diagnosis is not made. In the excitement usually accompanying the discovery of a person in a comatose state, the possibility of escaping gas may be overlooked, and the patient may be removed to a hospital before being seen by a physician. Under these circumstances the possibility of carbon monoxide poisoning may be entirely overlooked. Theoretically, the pinkish flush of the skin should serve as a clue, but before this becomes visible the blood must contain a high concentration of carboxyhemoglobin and in dark skinned patients even then it may not be obvious. At autopsy, however, the striking pink color of the skin, and the cherry red color of the blood and organs, sometimes furnish the diagnosis when it had not been made while the patient was living.

It is important to make a prompt diagnosis first because on it depends the type of treatment, and secondly because it may have medicolegal importance. In any obscure case of coma, the possibility of carbon monoxide poisoning should be given consideration, especially if marked spasticity of the extremities and bilateral hyperactive deep reflexes are present. To establish the diagnosis, a sample of blood should be taken immediately and sent to the laboratory for determining the presence of carboxyhemoglobin by means of the spectroscope. A qualitative test may be done by diluting a few drops of blood and then adding two drops of 10 per cent sodium hydroxide. A light pink solution instead of the normal brownish color indicates the presence of carbon monoxide combined with hemoglobin.

An understanding of the physiology of carbon monoxide is essential for rational treatment. Hemoglobin has an affinity for carbon monoxide which is from 200 to 300 times greater than for oxygen. Thus hemoglobin forms a stable compound with carbon monoxide which is carboxyhemoglobin, and the quantity of this compound thus formed depends on the concentration of carbon monoxide in the inspired air. Air containing 0.07 per cent carbon monoxide will combine approximately half the hemoglobin of the blood. Fortunately, the formation of carboxyhemoglobin is a reversible reaction, and as soon as the carbon monoxide is removed from the air, oxygen gradually replaces the combined carbon monoxide.

Treatment therefore consists in having the patient immediately breathe fresh air. Artificial respiration may have to be carried on. If possible pure oxygen should be administered with 5 to 7 per cent carbon dioxide. The latter stimulates respiration and thereby hastens the elimination of carbon monoxide. Treatment should be continued at least thirty minutes or more after the patient has regained consciousness since it is not uncommon to find the patient again lapse into unconsciousness. Drugs are of no benefit. Caffeine probably does no harm, but is of questionable value. To protect against hypostatic bronchopneumonia, it is essential to keep the patient in bed after recovery from the acute poisoning. A. J. Q.

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« « « EDITORIALS » » »

Appendicitis

APPENDICITIS has been recognized by the medical profession since the fourteenth century when John of Arderne described "passio iliaca." Until the last of the nineteenth century it was treated medically as inflammation of the bowel, typhilitis and perityphilitis with remarkable results in some instances (Boehmer). The clinicians of the seventeenth and eighteenth centuries described appendicitis and its clinical behavior very accurately (Fernel, Hodgkins). Fritz began the present attack in 1886 with his paper on "Perforating Inflammation of the Vermiform Appendix with Special Reference to Its Early Diagnosis and Treatment." Since then the clinical battle has been a more or less continual fight. The research angle has been introduced recently by Wangensteen and his coworkers. In 1936 in *The Quarterly Cumulative Index* there were 500 titles on appendicitis.

What does all this bring us to clinically? A higher mortality rate which has gradually increased from around eleven per hundred thousand to seventeen and eighteen per hundred thousand, and in some instances to thirty-eight and even higher per hundred thousand. Only recently has the trend been slightly lower. The morbidity associated with this mortality does not enter into this clinical picture.

What can we do about it? We know that the older clinical surgeons and the surgeons of the previous generation had lower mortality rates based on large series of cases (Ochsner, Murphy, Finney, Deaver, Mayo). Their record can be equalled again, and it ought to be better. An analysis of the literature shows that increased mortality is always associated with rupture and dissemination of the inflammation. Our job seems to be directed along these lines: to prevent patients from getting to the rupture stage; and, secondly, to improve the treatment when rupture occurs.

The earlier the physician sees, diagnoses, and institutes treatment, the fewer the number of ruptures. The public must cooperate and the physician be alert. Old and young people tolerate infection poorly and will necessarily give a higher mortality rate. The longer the elapse of time before treatment is instituted, the higher the mortality. Catharsis, whether by the patient or on order of the physician, increases the mortality rate 300 per cent or more.

In rupture, the physician should see that his special form of treatment produces results which compare favorably with the better results obtained elsewhere. Lower mortality statistics are not obtained by wishful thinking, and memory is often convenient but very inaccurate and confusing.

The medical profession needs the help of the laity and the pharmacist. This must be brought about by education. The job of education belongs to the medical profession.

. . . . THE PRESIDENT'S PAGES . . . .

Well, Why Not?

EVERY once in awhile someone has a new idea. Sometimes the idea affects a small group of people and sometimes it affects large masses of people. Adolf Hitler had a new idea when, with a spearhead movement, he cut the French line with a deep thrust. The French generals failed with the time-honored flanking movement. Could a new idea be used with success in the program of the annual meeting?

I have had occasion for a number of years to attend the meetings of my county medical society very regularly, and I know from experience that the secretary, about two weeks before the meeting, calls upon two medical men of some repute to come and talk to us. Generally these men travel a distance of eighty to one hundred miles and sometimes farther. They usually talk upon a subject which is of special interest to themselves, their hobby perhaps. Ninety seven per cent of the men go away without getting anything out of the talks, not that they are incapable of learning, but due to the fact that they are not interested in the subject. They are satisfied, of course, because it has always been so, is done so everywhere else. Anyone who dares to suggest some other type of program is put down as a lout. The whole procedure seems to be a rite in every sense of the word—like the ritual of a lodge or church service.

The Government, a few years ago, stepped into northern Wisconsin and wanted to improve the quality of obstetrics. The gentleman who came to talk to us spent his time in speaking upon cesarean section. I suppose it was a subject close to him, but the quality of obstetrics was not improved.

An active practitioner, called upon on short notice, and unless he is a teacher in a medical school, must almost of necessity talk upon a subject with which he is familiar. In many cases it is a rare condition and of no value to his audience. What the general practitioner needs and wants are the fundamentals of medicine; he needs them often and in large doses.

Approaching the question of a change in the program of the annual meeting of course makes one apprehensive. To suggest such a thing, to suggest disturbing a time-honored procedure is to make one a candidate for that peculiar individual known as a "nut." However, I feel very little is gained by the average doctor attending such a meeting from the usual run of papers presented at such a gathering. Those invited naturally speak upon intricate subjects of special interest to them; that is, they usually do.

The audience sits and swelters in the heat. I have often wondered just how much of value is obtained. Those specializing in diseases of the nose and throat, or in x-ray, etc., cram their efforts into a day and call it a job. Yet these men who specialize have their own journals, have their own meetings, and are in no way dependent upon a state society meeting program to, in many instances, enlighten them. So, upon the whole, I believe that the average run of standardized medical meetings is a flop if you evaluate a meeting as a place to learn new and better things.

The "round table" of recent years is a great step forward. Every ticket is sold out, on most occasions, in advance. Here the doctor feels he can get close to the leader and also learn a great deal through questions and argument.

The scientific booths offer a lot and can be made better by the presence, in most cases, of the man who worked out the exhibit. Information passed out by minor assistants is of questionable value. The liberal sprinkling of chairs for the foot weary doctors and larger booths which would hold about twenty-five would be a fine thing. The exhibitor could really carry on a "round table" discussion.

Personally, I have more faith in a good state medical journal, bringing to the practitioner each month something which will help him to improve himself, than a mass of presented papers. Personally, I would like to see a three-day meeting with all or nearly all general assemblies. I would like to see and hear very great and capable men in medicine address such a group on the present drifts in medicine, whether they be economics, diagnosis, treatment, new and important drugs, or what not. Then I would like to hear a couple of outstanding men talk upon education in general. If medicine has taken on for good the mantle of science, I can't see why we would not be improved by listening to other men in allied or totally different scientific fields talk to us. I would like to see the specialist and the general practitioner thrown together in a common assembly.

I have seen the coming program for the September session. I note there will be quite a number of papers on industrial medicine. Without being pessimistic I feel some of them will prove uninteresting to many. Upon the other hand, it might be very educational if the various speakers formed themselves into a round table discussion and let the rest of us listen in. It seems to me that by listening to the arguments back and forth we might grasp quickly and fully what is to become an important field in medicine.

Sooner or later in Wisconsin there is going to be a revival in medical education or perhaps a better expression would be postgraduate education. We have made the effort by sending a flying squadron about the state. Most men think they are fine but they are not well enough attended. At any rate, those behind the movement have made a sincere effort and put much time in it.

Anyway, some time and, I hope soon, we are going to have to do something about keeping 85 per cent of the general practitioners in this state up on, and alert to, the 85 per cent of the usual diseases with which he has to cope.

We have a column in the JOURNAL which will be glad to print any ideas for or against my proposal.

In closing, may I say, don't forget that the fellow who always agrees with you is either a nut or is getting ready to skin you.

"Except ye utter words easy to be understood how shall it be proven what is spoken."

—ST. PAUL.

R. G. Arum

THE WOMAN'S AUXILIARY

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National Convention

By MRS. FRANK W. POPE
President, Racine

IT WAS all they said it would be and more, and I am sorry that more Auxiliary members from Wisconsin were not present to enjoy the interesting events on the program. The weather was exceptionally fine, which added to our enjoyment.

Social events included a tea at Sherry's, dinner at the Waldorf at which Oscar himself appeared to greet us, an exceptional musical program the same evening, and luncheons each day. The women attending these events were provided with fresh flowers, and some 400 women who were fortunate enough to obtain tickets for a skit at the Elizabeth Arden Salon each received a handsome gift. There were sight-seeing trips and courtesy cards to the large stores, as well as plenty of time to visit the fair.

The sessions at the Pennsylvania Hotel were both interesting and instructive, the women in all departments doing their work cheerfully and well. A spirit of extreme friendliness prevailed. Mrs. Rollo K. Packard of Chicago, Illinois, retiring president, and Mrs. Carlton F. Potter of Syracuse, New York, convention chairman, to whom great credit is due, worked diligently for months that we might enjoy the hospitality so graciously extended to us.

It was a pleasure to greet Mrs. Virgil E. Holcombe, the new national president, who is from West Virginia. She is charming and able and seems to enjoy continuing the work that has been carried on so well by her predecessors. Mrs. Roscoe E. Mosiman, Seattle, Washington, who received special praise for her work as national public relations chairman last year, is the new president-elect. Due to the limited time, all state reports were not read, but those we heard showed earnest effort and intense interest in the work of the Auxiliary.

Busy as he was, our own Dr. Rock Sleyster, retiring president of the American Medical Association, addressed a luncheon meeting, giving an entertaining and humorous talk. It was a proud moment for the members of the Wisconsin Auxiliary.

I was proud when Mrs. John J. Ryan of St. Paul, Minnesota, national historian, told me of the splendid response of our own Mrs. Cornelius A. Harper of Madison, chairman of archives and history, to her request for assistance in the compilation of the history of the National Auxiliary. This has been a great task, and we are happy to have contributed to it.

Mrs. Eben J. Carey, Wauwatosa, and Mrs. George H. Ewell, Madison, have been honored with important posts on the National Board. Mrs. Carey was elected to the Board of Directors for two years, and Mrs. Ewell was appointed press and publicity chairman. For many years Wisconsin has been represented on the Board by conscientious women,

and it is gratifying to know that they have contributed of their time and effort to this well established Woman's Auxiliary to the American Medical Association.

It was with regret that the Wisconsin delegates said goodbye to old and new friends, but we find pleasure in looking forward to the next meeting to be held in Cleveland in 1941. I urge you to get into the habit of attending these national conventions with your husband, whether or not you are an Auxiliary member. You will find it well worth while. In the meantime, don't forget to make your plans now to attend the state convention in September. Mrs. Carey, convention chairman, is hard at work on plans for your entertainment, so we want you to come and have a good time.

Plans Announced For Annual Meeting of Auxiliary, September 17 to 19, in Milwaukee

A MOST cordial invitation is extended to the wife of every physician in the State of Wisconsin to attend the annual meeting of the Woman's Auxiliary to the State Medical Society, to be held in Milwaukee, September 17 to 19, and to take part in the entertainment. All wives of physicians, whether or not they are members of a county auxiliary, are most cordially invited to participate in all activities. Every effort is being made to make your visit in Milwaukee a pleasant one.

The co-chairmen of the Committee on Arrangements are Mrs. Charles F. Fidler and Mrs. Harry J. Heeb, both of Milwaukee. The members of the Woman's Auxiliary to the Winnebago County Medical Society, with Mrs. F. Gregory Connell and Mrs. Earl B. Williams of Oshkosh as co-chairmen, will serve as hostesses with the members of the Woman's Auxiliary to the Medical Society of Milwaukee County.

Mayor Carl F. Zeidler will extend the welcome to the City of Milwaukee.

We have been most fortunate in securing the Reverend Raphael C. McCarthy, S. J., president of Marquette University, as speaker for the luncheon on Wednesday. His topic will pertain to mental health. Father McCarthy is a most interesting and entertaining speaker and is well known nationally as an educator and author. Cards will follow. Wednesday night will be FIESTA NIGHT with Mexican music and entertainment. The Thursday luncheon will be followed by "News and Fashions." Mrs. Frank W. Pope of Racine, president of the Woman's Auxiliary, will preside at all meetings. Every Auxiliary member and guest is urged to register and make reservations for luncheons early.

A complete program with names of members of committees will be published in the September issue of the WISCONSIN MEDICAL JOURNAL.

Mrs. Frank W. Pope, Racine, President State Auxiliary.

Preliminary Program of Auxiliary

Tuesday, September 17, 1940

P. M.

2:00–4:30 Registration—Hotel Schroeder

7:00 Board of Directors' Dinner—University Club
Mrs. Frank W. Pope, president, presiding

Wednesday, September 18, 1940

A. M.

10:00 General Meeting—Club Rooms, Third Floor, Hotel Schroeder
Mrs. Frank W. Pope, president, presiding
Invocation
Convention Announcements — Mrs. Eben J. Carey, chairman
"Greetings,"—The Hon. Carl F. Zeidler, Mayor of the City of Milwaukee
Address of Welcome—Mrs. C. D. Partridge, president, Woman's Auxiliary to the Medical Society of Milwaukee County
Response—Mrs. W. Homer Krehl, president, Woman's Auxiliary to the Dane County Medical Society
In Memoriam
Convention Rules and Procedure—Mrs. William M. Jermain, parliamentarian
Minutes of Annual Meeting, 1939 — Mrs. Homer M. Carter, recording secretary
Reports of Officers
President—Mrs. Frank W. Pope
Treasurer—Mrs. Edwin P. Bickler
Corresponding Secretary—Mrs. Charles E. Constantine
Recording Secretary — Mrs. Homer M. Carter
Reports of Chairmen
Archives—Mrs. Cornelius A. Harper
Finance—Mrs. Arthur J. McCarey
Hygeia—Mrs. Irenaeus N. Tucker
Organization—Mrs. Ernest S. Schmidt
Philanthropic—Mrs. Edgar F. Andre
Press and Publicity — Mrs. Arnold S. Jackson
Program—Mrs. James C. Hassall
Public Relations—Mrs. Ira F. Thompson
Report of Chairman of Committee on Credentials and Registration
Announcements

P. M.

1:00 Luncheon and Bridge—Hotel Schroeder
Speaker — Reverend Raphael C. McCarthy, S. J., president, Marquette University
Assistant Hostesses—Members of the Woman's Auxiliary to the Winnebago County Medical Society
Co-Chairmen—Mrs. F. Gregory Connell, Oshkosh
Mrs. Earl B. Williams, Oshkosh

—Photograph by Stein, Milwaukee.

Mrs. Eben J. Carey, Milwaukee, Convention Chairman, State Auxiliary.

8:30 Fiesta — Banquet Room, Fifth Floor, Hotel Schroeder
Entertainment
Refreshments

Thursday, September 19, 1940

A. M.

9:30 General Meeting—Club Rooms, Third Floor, Hotel Schroeder
Mrs. Frank W. Pope, president, presiding
Minutes of Wednesday Session
Report of Convention Chairman
Reports of County Presidents
Report of Resolutions Committee
Report of Nominating Committee
Election of Officers
Installation of New Officers
Final Report of Chairman of Committee on Credentials and Registration
Announcements
Adjournment

A. M.
11:30 Post-Convention Meeting of Board of Directors — Club Rooms, Third Floor, Hotel Schroeder
Mrs. Donne F. Gosin, president, presiding
P. M.
1:00 Luncheon, "News and Fashions" — Hotel Schroeder
6:45 Annual Dinner — Crystal Ballroom, Hotel Schroeder

ANNUAL MEETING COMMITTEE,
MRS. EBEN J. CAREY, *chairman*,
MRS. CHARLES F. FIDLER, *co-chairman*,
MRS. HARRY J. HEEB, *co-chairman*.

Manitowoc

Members of the Woman's Auxiliary to the Manitowoc County Medical Society, meeting at the Hammond Farm on June 19, named Mrs. E. C. Cary of Reedsville the president-elect of their organization and Mrs. C. E. Wall of Manitowoc secretary-treasurer, as they closed their business activities for the season. Mrs. T. A. Teitgen of Manitowoc, named president-elect last year, will succeed Mrs. T. H. Rees as president of the auxiliary for the ensuing year, when the auxiliary reconvenes in the fall.

Those acting as hostesses at the June 19 meeting were Mrs. F. W. Hammond and Mrs. R. W. Hammond of Manitowoc and Mrs. E. W. Huth of Mishicot. Fourteen members were present.

Winnebago

The Woman's Auxiliary to the Winnebago County Medical Society held its annual picnic on June 24 at the Recreational Building at Neenah. At bridge in the afternoon the winners were Mrs. W. P. Wheeler of Oshkosh and Mrs. S. D. Greenwood and Mrs. H. F. Beglinger, both of Neenah. Visitors included Mrs. George Pratt, Jr., and Mrs. Gordon Peterson of Neenah and Miss Marguerite Senn and Mrs. Charles H. Behnke of Oshkosh.

A picnic luncheon was served, the committee in charge including Mrs. R. F. Wagner of Oshkosh and Mrs. G. R. Anderson of Neenah as chairmen, Mrs. J. F. Stein and Mrs. J. J. Kronzer of Oshkosh, Mrs. G. H. Williamson and Mrs. H. F. Beglinger of Neenah, and Mrs. P. T. O'Brien of Menasha. This was the auxiliary's last meeting before fall.

SOCIETY PROCEEDINGS

Ashland—Bayfield—Iron

The Ashland–Bayfield–Iron County Medical Society met in Ironwood, Michigan, June 26 at 6:30 p. m. Drs. H. F. Ringo and M. W. Garry, both of Montreal, Wisconsin, discussed the prevention of silicosis in iron miners. A feature of the meeting was a demonstration, at the Montreal Mining Company offices, of dust counting and the use of respirators to give the underground miners dust-free surface air. Thirty attended.

Jefferson

The Jefferson County Medical Society recently cooperated in an industrial tuberculosis survey with the Jefferson county board, Forest Lawn Sanatorium, the Wisconsin Anti-Tuberculosis Association and industrial firms of the county. A traveling fluoroscopic unit of the Anti-Tuberculosis Association, complete in a trailer, was brought to the Jefferson Knitting Mills, Carnation Company, Union Upholstering Company, Copeland and Ryder Shoe Company, Stoppenbach Sausage Company, Jefferson Wood Products and other Jefferson firms for the conduction of chest clinics, between July 1–16.

La Crosse

The La Crosse County Medical Society met at the Maple Grove Country Club, West Salem, Wisconsin, June 11. The meeting was in the form of a golf tournament for members of the society. Dinner was served to the golfers at 7 p. m.

Marathon

The Marathon County Medical Society held a special meeting in Wausau on June 20. A resolution regarding the handling of medical relief cases was passed.

The meeting was preceded by a dinner, at which Dr. George H. Stevens, president of the society, presided. Dr. Joseph F. Smith, delegate of the State Medical Society to the American Medical Association, discussed events at the Association's session in New York City, June 10–14.

Milwaukee

Dr. J. G. Garland, Milwaukee, successfully defended his championship title in the thirteenth annual golf tournament of the Medical Society of Milwaukee County, June 27, at the Tuckaway Country Club, his "home course." Dr. Garland's score was 77. Other prize winners in the tournament included: Drs. C. M. Steiner, John D. Charles, Milton Klumb, R. E. McDonald, A. C. Gorder, David Cleveland, E. P. Bickler, F. J. Schubert, C. S. Stern, George Fellman, D. F. Pierce, S. R. Mitchell, R. J. Russell and George Meloy.

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met in Galesville, July 18, at 6 p. m. for dinner and a scientific program. Speakers of the evening were Dr. Walter Sexton, Marshfield, who discussed "Hematuria," and Dr. Lyman A. Copps, Marshfield, who spoke on "Interesting Eye Conditions," illustrating his remarks with colored lantern slides.

Central Wisconsin Society of Ophthalmology and Otolaryngology

The Central Wisconsin Society of Ophthalmology and Otolaryngology met at the Gateway Hotel, Land O' Lakes, Wisconsin, June 8 and 9. Attendants played golf in the afternoon of the first day of the session. In the evening, after dinner, Dr. Robert Von der Heydt, Chicago, discussed "Fundus and Anterior Eye Conditions," and Dr. O. E. Van Alyea, Chicago, "Irrigation of Frontal and Sphenoid Sinuses."

The June 9 meetings opened at 9 a. m. with another lecture by Dr. Von der Heydt, this time on "Skin Diseases Adjacent to the Eyelids." Dr. E. J. Zeiss, Appleton, also addressed the group; his subject was "Focal Infection in Ocular Disease." After a noon luncheon, Dr. Lyman A. Copps, Marshfield, presented a paper on "Petrositis," and Dr. E. O. Niver, Eau Claire, spoke on "Meningitis."

Fourth Councilor District

The members of the Fourth Councilor District of the State Medical Society of Wisconsin were banquet guests in June of Dr. B. I. Pippin, Richland Center, councilor for the district. Speakers at the event included Mr. J. G. Crownhart, secretary, and Dr. Ralph P. Sproule, president-elect, of the State Medical Society; Dr. W. T. Clark, Janesville, councilor for the Third Councilor District; and the Hon. Vernon W. Thomson, speaker of the Wisconsin Assembly.

Fifth Councilor District

Speakers at the afternoon session of the Fifth Councilor District of the State Medical Society, in Manitowoc, June 27, were Dr. Doris F. Hopkins of Northwestern University Medical School, Chicago; Dr. R. J. Jackman and Dr. R. C. Adams of the Mayo Clinic, Rochester, Minnesota; and Dr. E. L. Sevringhaus, University of Wisconsin Medical School, Madison. Dr. Hopkins spoke on "Allergy in General Medicine," Dr. Jackman on "Anorectal Disease," Dr. Adams on "Anesthesia in Proctology," and Dr. Sevringhaus on "Office Management of Diabetes."

At an evening banquet at the Catholic Center, Dr. R. G. Arveson, president of the State Society, gave an address and Dr. Eben J. Carey discussed "Medical Science and the Public." Officers elected for the coming year at the evening session included the following:

President—Dr. A. C. Radloff, Plymouth
Secretary—Dr. Leon D. Sobush, Manitowoc

Sixth Councilor District

An outstanding scientific program featured the meeting of the Sixth Councilor District of the State Society in Fond du Lac, June 27. Dr. J. Howard Johnson, Milwaukee, opened the program with his paper on "Fractures of the Hand." Three Chicago physicians connected with Loyola University School of Medicine presented addresses as follows: Dr. H. E. Schmitz, "Carcinoma of the Cervix;" Dr. George O'Brien, "Coronary Heart Disease;" and Dr. J. P. Greenhill (co-editor of the Year Book of Obstetrics and Gynecology), "Endocrinology in Obstetrics and Gynecology." Dr. C. Marshall Davison, medical director of Cook County Hospital, Chicago, spoke on "Acute Disease of the Abdomen."

Dr. S. E. Gavin, chairman of the Council of the State Society and councilor for the Sixth District, was toastmaster at the evening banquet served to the group at 6:30 p. m. Dr. H. E. Schmitz again addressed the doctors in the evening session.

Officers for the next year elected at the meeting are: Dr. G. W. Carlson, Appleton, president and Dr. W. W. Kelly, Green Bay, vice-president.

Ninth Councilor District

The Ninth Councilor District of the State Medical Society held its summer meeting in Marshfield, July 11. Dr. Walter C. Alvarez, Mayo Clinic, Rochester, Minnesota, and Dr. Walter Kearns, Milwaukee urologist, addressed the group in afternoon and evening sessions. Dr. Alvarez' discussions dealt with problems in gastroenterology and Dr. Kearns' with problems in urology. A dinner was served to the doctors at the Hotel Charles in the evening; the scientific sessions were held at St. Joseph's hospital.

"INFORMATION, PLEASE"

On July 26, the American Medical Association reported only 1,427 of the 3,523 questionnaires sent out by its Committee on Medical Preparedness to Wisconsin physicians have been returned. If any considerable proportion of physicians fail to furnish the information requested in this questionnaire, the work of the committee on the formation of an adequate military and civilian medical service in event of war will lack force and significance. All who have not filled in and returned the questionnaire are urged to do so AT ONCE.

News Items and Personals

Dr. Harry R. Foerster, Milwaukee, has been elected secretary of the American Dermatological Association, to serve for a five-year term. The election was made at the meeting of the Association in Colorado Springs, Colorado, May 30.

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Dr. Reuben Stiehm and *Dr. W. H. Oatway, Jr.*, of the medical department of the University of Wisconsin Medical School, have been named co-physician consultants on the staff of the Morningside Sanatorium in Madison. The sanatorium was founded and managed for many years by the late Dr. Louis Head.

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Dr. A. E. McMahon, Glenwood City, is taking a three-month postgraduate course at the Cook County Graduate School of Medicine in Chicago. During his absence *Dr. C. A. Olson*, Hammond, will act as secretary of the Pierce–St. Croix County Medical Society.

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Dr. W. A. Rauch, Manitowoc, spoke recently to the Rotary Club of Manitowoc on "The Pros and Cons of Socialized Medicine."

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Dr. E. R. Krumbiegel, 32 years of age, has been named by Mayor Carl F. Zeidler of Milwaukee, to fill the unexpired term of *Dr. John P. Koehler* as health commissioner of the city. One of the youngest health commissioners in Milwaukee history, Dr. Krumbiegel has been connected with the health department since 1936, being appointed director of the contagious diseases division in that year by Dr. Koehler after placing first in an examination for the position. A native of Milwaukee, he was graduated from Marquette University School of Medicine in 1935.

Among the new commissioner's first duties was the appointment of a deputy to replace *Dr. E. V. Brumbaugh*, who has resigned. Dr. Brumbaugh has served on the staff of the health department for twenty-one years.

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St. Mary's Hospital, Sparta, celebrated its 25th anniversary on July 15.

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Dr. J. F. Klepfer, who since the death of Dr. W. A. Deerhake on April 10 has been serving in the capacity of acting superintendent of the Central State Hospital for the Criminal Insane, Waupun, has been named superintendent of the institution. Announcement of his appointment was made July 1 by Mr. Frank C. Klode, Madison, director of the State Board of Public Welfare. Dr. Klepfer, who is 35 years of age, was graduated in 1930 from the Indiana University School of Medicine.

Dr. H. W. Virgin, Jr., Madison, attended the New York session of the American Medical Association in June where he demonstrated compression fractures of the spine.

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At a meeting of the La Crosse Board of Health, July 5, *Dr. Walter J. Jones* was named board chairman. *Dr. W. E. Bannen*, La Crosse, was made a member of the board.

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Dr. James S. Vedder and *Dr. Edward J. McGinn* have formed a partnership for the practice of medicine in Marshfield.

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Dr. W. D. Stovall, Madison, addressed the Racine Business and Professional Women's Club, July 25, on "Wisconsin's Contribution to the Field of Medicine."

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Dr. Walter M. Kearns, Milwaukee, won a first prize cash award and a medal for an exhibit and paper presented at the American Urological Association convention in Buffalo, N. Y., recently.

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"Time turns back fifty-two years for the wayfarer who strays off busy N. 3rd St., and climbs the stairs to the offices of *Dr. Louis G. Nolte*," a Milwaukee Journal reporter recently stated. Dr. Nolte still occupies the same offices in which he started his practice in 1888 as assistant to Dr. Nicholas Senn and has changed the furnishings little since that time. He has an extensive medical library of considerable value.

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Physicians Needed for Army Service

The physician, like every other American, has become actively interested in our national security and stands ready to contribute his services as required for military preparedness.

The immediate problem in this connection is one that concerns the War Department, and primarily the young physician. The War Department must procure sufficient additional personnel from the medical profession to augment the medical services of the Regular Army as the various increases are made in the strength of the Regular Army, as authorized by Congress to meet the partial emergency. The young physician is especially concerned because it is usually advantageous, and is often more convenient for him to serve with the Army.

Present plans of the War Department are designed to make service attractive and instructive for the young physician. If the physician holds a Medical Corps Reserve commission he can be ordered to active duty if he so requests. If he does not hold a

commission, but is under thirty-five years of age and is a comparatively recent graduate of an accredited school, he may secure an appointment in the Medical Corps Reserve for the purpose of obtaining extended active duty for a period of one year or longer. Duty is given at general hospitals, station hospitals, and with tactical units, and embraces all fields of general and specialized medicine and surgery. Excellent postgraduate training is obtainable in connection with aviation medicine. After serving six months of active duty in the continental United States, a reserve officer may request duty in Hawaii, Panama, or other United States territories and possessions. The initial period for duty is for one year and yearly extensions are obtainable thereafter until the international situation becomes more clarified and our domestic military program becomes stabilized.

Many young doctors who have served with the Army on extended active duty have taken the competitive examination for entrance into the Medical Corps of the Regular Army. Extended active duty affords an excellent opportunity for the physician to observe modern military medicine and the facilities that exist for a complete and comprehensive medical practice.

Pay is according to rank, and, including subsistence and quarters allowances for an officer with dependents, amounts to an annual sum of $3,905 for a Captain and $3,152 for a First Lieutenant; or, without dependents, to an annual sum of $3,450 for a Captain and $2,696 for a First Lieutenant. In addition, reimbursement is made for travel to duty station and return.

Further information may be obtained by writing to The Surgeon General, U. S. Army, Washington, D. C.

Coming Events

Evaluation study of serologic tests for syphilis to be conducted.—More than five years ago the Committee on Evaluation of Serodiagnostic Tests for Syphilis, in cooperation with the United States Public Health Service, conducted a study to evaluate original serologic tests for syphilis or modifications thereof in the United States. The results of this study were published shortly after the investigation was completed. (Ven. Dis. Inform., Washington, June, 1935.)

Consideration is now being given by the Committee to the organization of a second evaluation study of original serologic tests for syphilis or modifications thereof within the next year. If the need for an investigation of this kind seems to justify the cost, invitations will be extended to the authors of such serologic tests who reside in the United States, or who may be able to participate by the designation of a serologist who will represent them in this country. The second evaluation study will be conducted utilizing methods comparable to those employed in the first study. (J. A. M. A., Dec. 1, 1934.)

Serologists who have an original serologic test for syphilis or an original modification thereof and who desire to participate in the second evaluation study should submit their applications not later than October 1, 1940. The applications must be accompanied by a complete description of the technic of the author's serologic test or modification. All correspondence should be directed to the Surgeon General, United States Public Health Service, Washington, D. C.

American Board of Ophthalmology announces examination dates.—*There will be only one written examination during 1941.* This will be held in various cities throughout the country on March 8.

Candidates enrolled in the Preparatory Group who have been advised that they will be eligible for examination during 1941 should make application *at once* to take this written examination.

Application must be made on the regular blanks provided for the purpose and must be received in the Board Office before December 1, 1940.

Oral examinations 1941	*Deadline for case reports*
Cleveland, May or June	February 1
October (place to be announced later)	July 1

A special oral and clinical examination will be held on the Pacific Coast during 1941 providing there will be enough candidates to warrant it. Applications for this examination should be filed before September 1, 1940, so that the Board may complete necessary arrangements.

If you plan on taking your examination during 1941, please write at once to the Board Office for formal application blanks, indicating your preference of examination place.—American Board of Ophthalmology, 6830 Waterman Avenue, St. Louis, Missouri.

Sixth Annual Meeting, Mississippi Valley Medical Society.—The meeting will be held at the Hotel Fort Armstrong, Rock Island, Illinois, September 25–26–27. A program will be given by thirty-two clinician-teachers who will give over sixty lectures, demonstrations, round table discussions, etc. A special feature will be the numerous short instructional courses, forty-one in number. At a banquet on the evening of September 26, Dr. Nathan B. Van Etten, president of the American Medical Association, and the presidents of the Illinois, Missouri and Iowa state medical societies will speak. The winner of the Mississippi Valley Medical Society's third annual essay contest—Dr. John F. Casey, Boston, will present his winning essay, "Study of the Use of Sulfapyridine and Sulfathiazole in Pneumonia with Particular Reference to the Treatment of Pneumonia by the General Practitioner," September 26.

Further information may be secured from Dr. Harold Swanberg, secretary of the society, W. C. U. Bldg., Quincy, Illinois.

Pan American Congress of Ophthalmology.—The first Pan American Congress of Ophthalmology, bringing together a large group of eye specialists of the Western Hemisphere, meets in Cleveland, Ohio, October 11 and 12.

The American Academy of Ophthalmology and Otolaryngology, a society of more than 2,500 specialists of the United States, undertook sponsorship of the Pan American Congress as a means of promoting greater solidarity and wider acquaintance among medical men of the Americas. The need of such a gathering was emphasized by the postponement of the International Congress of Ophthalmology, which was to have met in Vienna in 1941, made necessary by the European conflict.

The first event of the congress will be a joint banquet with the Academy Wednesday evening, October 9, at which Dr. Frank Brawley, Chicago, president of the Academy, will preside. Thursday afternoon, October 10, the official delegates appointed by the various governments will meet with representatives of ophthalmologic societies to draw up a constitution and make plans for future meetings.

Official recognition of the congress will be extended by the city of Cleveland at a reception Friday evening, October 11.

The scientific program will occupy two days, Friday and Saturday, October 11 and 12. Papers will be divided equally between speakers from the Latin American countries and those from the United States. Papers in Spanish or Portuguese will be discussed by English speaking physicians and those presented in English will be discussed by Latin American speakers. Slides showing a resume of each paper are to be shown on a screen in the two languages other than the one being spoken.

The committee of the American Academy of Ophthalmology and Otolaryngology which is arranging the Pan American Congress is made up of Drs. Harry S. Gradle, Chicago; Conrad Berens, New York, and Moacyr E. Alvaro, Sao Paulo, Brazil.

Examinations, American Board of Obstetrics and Gynecology.—The annual written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 4, 1941, at 2:00 p. m. Candidates who successfully complete the Part I examinations proceed automatically to the Part II examinations held later in the year.

The following action regarding case records to be submitted by candidates taking the Group B, Part I, examination was passed by the Board at its annual meeting in Atlantic City, N. J., on June 6, 1940: "Case records submitted by candidates must be of patients treated within four years prior to the date of the candidate's application. The number of cases taken from one's residency service should not be more than half (25) of the total number of fifty (50) cases required."

Applications for admission to Group B, Part I, examinations must be on file in the Secretary's office not later than October 5, 1940.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting at Cleveland, Ohio, immediately prior to the June 1941 meeting of the American Medical Association.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I and Part II examinations.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1011 Highland Building, Pittsburgh (6), Pennsylvania.

"Osler at Old Blockley"

The painting, reproduced above, which depicts one of Osler's outstanding contributions to medicine, namely, bringing medical students to the bedside of the patient for clinical study, was unveiled at the dedication of the Osler Memorial Building on the grounds of the Philadelphia General Hospital in June and was later exhibited at the American Medical Association's annual session in New York City.

In the painting, done in oil by Dean Cornwell, Osler is shown at the side of an elderly patient on the hospital grounds. Surrounding Osler and the patient are interns who have stopped with him as they were on their way to the autopsy house to observe one of his famous postmortems. This autopsy house, now the only Osler Memorial Building in the United States, is shown in the background. The memorial was made possible by a grant from John Wyeth & Brother.

"Osler at Old Blockley" is the second painting in the series "Pioneers of American Medicine" sponsored by John Wyeth & Brother as part of a project to highlight the contributions of Americans to the advancement of medicine. "Beaumont and St. Martin" was the first painting in the series.

Colored reproductions of "Osler at Old Blockley," suitable for framing may be obtained free by addressing requests to: Wisconsin Medical Journal, 917 Tenney Bldg., Madison, Wisconsin.

OFFICIAL NOTICE OF PROPOSED CHANGE IN CONSTITUTION

The following proposed amendment to Section 2, Article IX of the Constitution of the State Medical Society of Wisconsin—submitted at the 1939 session of the House of Delegates of the State Society by the Jefferson County Medical Society through Dr. W. S. Waite of Watertown, delegate—will be voted on by the House at its September 1940 session in Milwaukee.

Amendment Relative to Elections

Section 2. The President, President Elect, Speaker and Vice-Speaker shall be elected by the House of Delegates. The Secretary and Treasurer shall be elected by the Council. Councilors shall be elected at a meeting of their respective district societies held within the twelve months' period prior to the annual meeting of the State Society at which the term of Councilor expires. Certification of such election, signed by the President and Secretary of the councilor district society, shall be placed in the hands of the Secretary of the State Medical Society prior to the annual meeting of the Society in the year in which the term of such Councilor expires. In the event a councilor district fails so to certify its election, the election for Councilor of such district shall be by the House of Delegates. Notices of election of a Councilor in a district shall be incorporated in a mailed notice to the members of the district at least seven days before the meeting at which the election is to be held.

Election, where more than one nomination is received, shall be by ballot and a majority of votes cast shall be necessary to elect. Each candidate for Councilor must be a resident of the district which it is proposed to represent and no person known to have solicited votes for or sought the office of Councilor shall be eligible for the current election. Other procedure essential to the election shall be governed by Robert's Rules of Order.

The officers, except the Councilors, shall be elected annually. The terms of Councilors shall be for three years, and all officers shall serve until their successors are elected and installed. There shall be elected one Councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional Councilor for each additional 250 members or major fraction thereof. As nearly as possible, one-third of the members of the Council shall be elected each year.

The President-Elect shall automatically succeed the office of President at the conclusion of his one-year term of President-Elect.

BIRTHS

A daughter, Cecile Elizabeth, to Dr. and Mrs. Robert I. Hiller, Milwaukee, July 11.

A son to Dr. and Mrs. E. H. Tashkin, Milwaukee, July 7.

A son, George Thomas, to Dr. and Mrs. George W. Walter, Racine, July 5.

MARRIAGES

Dr. F. C. Jacobson, Washburn, and Miss Gertrude Peterson, Prescott, on July 6.

Dr. Ralph T. Rank, Milwaukee, and Miss Marie Foeller, Green Bay, on June 17.

DEATHS

Dr. A. P. Campbell, East Ellsworth, died July 15 at his home.

He was born in 1894. He was graduated from the University of Pennsylvania School of Medicine in 1924, and received his license to practice in Wisconsin in 1929.

Dr. Campbell was a veteran of the World War. He was a member of the Pierce–St. Croix County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Dr. C. A. Dawson, River Falls, president of the Pierce–St. Croix County Medical Society, writes: "Dr. Campbell was one of the most valued members of our society, a firm believer in organized medicine, and an active fighter for all those things that stand for good." He was unmarried; his only survivors are one brother and two sisters.

Dr. H. B. Gifford, Juda, died July 15 in a Monroe hospital. He was born in 1859 and was graduated in 1883 from Rush Medical College, Chicago. He returned to his native town, Orfordville, Wisconsin, to open his practice in 1885 and remained there until 1895. He then moved to Juda where he continued in practice until his death.

Dr. Gifford is said to have owned one of the first automobiles in his community. The *Monroe Times* states, "He took pride in his carefully-kept records showing that he had officiated at the birth of 2,434 infants."

Dr. Gifford was for many years a member of the Green County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. Surviving him is one daughter.

Dr. Avery LeRoy Myrick, formerly of De Soto, died at his home in Daytona Beach, Florida, May 21, after an illness of over four years. He was 56 years of age.

Dr. Myrick was graduated in 1910 from the University of Alabama, then located in Tuscaloosa. He practiced in De Soto for seventeen years, moving there in 1919 from Eastman, Wisconsin. He served with the American Expeditionary Forces in France during the World War. For many years he was a member of the Vernon County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow, a son and a daughter.

Dr. Homer Sylvester, Madison, died in a Madison hospital on June 12 from the effects of a stroke. He was 71 years of age.

Dr. Sylvester was graduated from the University of Pennsylvania School of Medicine in 1895. Thereafter he engaged in private practice in Milwaukee, Montfort and Madison. He served as captain in the United States army during the World War. For nine years he was a member of the medical staff of Mendota State Hospital.

Surviving the doctor are his widow and a daughter.

SOCIETY RECORDS

New Members

G. B. Wiles, 616 North Eighth Street, Sheboygan.

John Cary, 630 North Eighth Street, Sheboygan.

V. F. Neu, Sheboygan Clinic, Sheboygan.

Carl Greenstein, 816 North Eighth Street, Sheboygan.

E. M. Baskerville, Wisconsin Rapids.

R. K. Pomeroy, Port Washington.

Changes in Address

F. G. Zietlow, Brillion, to Andrews Building, Waukesha.

V. G. Springer, Winneconne, to Omro.

F. W. Leeson, Hollywood, Fla., to 349 Euclid Avenue, Beloit.

R. J. Dalton, Milwaukee, to Co. 654, C.C.C. Camp, Minocqua.

J. A. Evans, La Crosse, to 605 Commonwealth Avenue, Boston, Massachusetts.

A. J. Macht, Winnebago, to Department of Student Health, University of Wisconsin, Madison.

Bessie Mae Beach, Madison, to Division of Child Hygiene, East Alabama Health District, Opelika, Alabama.

Sidney Posner, Nekoosa, to Robstown, Texas.

B. L. Boynton, Madison, to Norfolk, West Virginia.

Winifred Ingersoll, Madison, to University of Wyoming, Student Health Department, Laramie, Wyoming.

R. H. Smits, Waunakee, to 5930 West Burnham Street, West Allis.

R. C. Buerki, Chicago, to 1300 University Avenue, Madison.

CORRESPONDENCE

JOURNAL ON ALCOHOLISM INAUGURATED

YALE UNIVERSITY
New Haven, Connecticut

July 1, 1940.

Editor,
Wisconsin Medical Journal,
Madison, Wisconsin.

Dear Doctor: Under separate cover I am sending you a copy of the first issue of the Quarterly Journal of Studies on Alcohol. With the discontinuance of the British Journal of Inebriety this is now the only scientific periodical in the English language devoted solely to problems of alcohol.

Alcoholism, I am convinced, is a public health problem of as great importance as that of syphilis—possibly more so. It has seemed to me that a primary step toward the solution of this problem is the collection and presentation of valid information concerning alcohol and alcoholism. I hope that the Journal will serve these purposes.

Recognizing the magnitude of the problem of alcoholism, the American Association for the Advancement of Science has recently formed the Research Council on Problems of Alcohol. The Council has chosen the Journal as its official organ.

I am faced with the problem of bringing this Journal to the attention of the numerous groups which might be interested in it. If you would care to give notice of its publication, I should be grateful.

Yours sincerely,

HOWARD W. HAGGARD, M. D.,
Editor.

Minutes of the Council; Milwaukee, June 23, 1940

1. Call to Order

The Council was called to order by Chairman Gavin at 9:00 a.m., Sunday, June 23, 1940, in the library of the University Club of Milwaukee.

2. Roll Call

The following were present, constituting a quorum: Councilors Gavin, Jegi, Clark, Butler, Fitzgerald, Krahn, Christofferson, Johnson, Bowen, Pippin, Pechous, Gramling; President-elect Sproule; Past-president Rector; Vice-speaker Kurten; Delegate to the A. M. A. Sargent; Dr. C. A. Dawson, chairman of the Committee on Public Policy; Secretary Crownhart; Assistant Secretary Larson; Messrs. C. H. Crownhart and R. B. L. Murphy, legal counsel for the Society; Mr. James O. Kelley, executive secretary of the Medical Society of Milwaukee County. Other guests were present for specific orders of business, as noted.

3. Approval of Minutes of March Meeting

Upon motion by Fitzgerald–Butler, the minutes of the March meeting as published in the May issue of the Wisconsin Medical Journal, were approved.

4. Modification of the 1940 Budget

Secretary Crownhart explained a proposed modification of the 1940 budget involving certain operating items for the executive office, and approval of such modification by the Executive Committee of the Council. The items and amounts which necessitate increase, to be supplied from the unappropriated reserve budget account, are as follows:

1. Add to budget for Item 3–5 "telephone and telegraph"	$ 500
2. Add to budget for Item 3–6 "supplies and light"	250
3. Add to budget for Item 3–7 "postage and printing"	250

4. Add to budget for Item 4–1 "legal"	600
5. Add to budget for Item 4–2 "special bulletins to members"	400
Total	$2,000
Minus savings on budget item 4–5 "graduate centers"	450
Net addition to budget from the $3,410 free account	$1,550
Balance then left unappropriated in 1940 budget	$1,860

After discussion, upon motion by Rector–Christofferson, the modified budget allowances were adopted unanimously.

5. Election of Life Members

After discussion by Past-president Rector, Secretary Crownhart, and Councilors Gavin and Christofferson, it was moved by Butler–Clark that the following group of Wisconsin physicians, qualified under the By-Laws, be granted life memberships in this Society: Dr. G. E. Baldwin of Green Lake; Dr. Carl von Neupert of Stevens Point; Dr. J. A. Bach of Milwaukee; Dr. William Hipke of Hustisford; and Dr. J. J. Looze of Wisconsin Rapids. The motion was carried unanimously.

6. Hospital Service Contracts

There were distributed to the councilors, mimeographed copies of correspondence between the executive offices of the Society, acting for the special committee of the Council, and Associated Hospital Service, Inc., which were read by Secretary Crownhart. He then explained proposed amendments which had been submitted to the Associated Hospital Service, Inc., which, if adopted, would bring their contracts on medical service benefits and operating policies into line with principles laid down by the State Medical Society and in conformity with the enabling law.

President-elect Sproule then discussed the work of the Interprofessional Relations Committee, of which he is chairman, in connection with certain points under consideration by the Society and the hospital service association. General discussion followed which was participated in by Councilors Christofferson, Gavin, Clark, Krahn, Butler, Past-president Rector, President-elect Sproule, and Secretary Crownhart.

At this point in the proceedings, according to previous arrangement by Dr. Sproule, the following persons representing Associated Hospital Service, Inc., entered the room for participation in the proceedings, looking toward a definite decision by the Council as to future action based on adoption or non-adoption of the suggested amendments to Associated Hospital Service, Inc.: Dr. E. T. Thompson, secretary; Mr. Joseph Norby, president; Mr. L. R. Wheeler, executive secretary; Mr. Joseph Moser, Reverend Herman Fritschel, Mr. T. L. McCormack, Mr. Neil Gleason and Mr. E. F. Luetzow, members of the board of directors; Dr. F. D. Murphy, member of the Interprofessional Relations Committee. Dr. J. E. Habbe, Milwaukee (Wisconsin representative, Inter-Society Committee for Radiology) also was present for this order of business.

Dr. Sproule explained events in which his committee participated, leading to the present meeting. Chairman Gavin called upon Mr. Norby, who then discussed the ramifications of the setting up and early operation of Hospital Service Association, Inc., including problems faced by the administration. General discussion followed, participated in by Mr. Norby, Councilors Clark, Christofferson, Gavin, Krahn, Butler, Bowen, Past-president Rector, Secretary Crownhart, Messrs. Wheeler and McCormack, and Reverend Fritschel. At this point the representatives of Associated Hospital Service, Inc. retired from the room, and discussion continued which was participated in by Councilors Bowen, Pechous, Butler, Gavin, Clark, Gramling and Christofferson; Past-president Rector; Delegate Sargent; Secretary Crownhart; and C. H. Crownhart, attorney.

The meeting then recessed for dinner at 12:30 p.m.

Chairman Gavin called the meeting to order at 2:00 p.m.

There was further discussion of the subject under consideration, by Councilors Butler, Jegi, Bowen, Fitzgerald, Gramling, Clark, Pippin, Christofferson, Past-president Rector and Vice-speaker Kurten.

Chairman Gavin asked that the Council express its wishes as to the future policy of the Society with respect to the problem involved, pointing out that the position of medicine had been made known for a long period of time, had been repeatedly presented in conference after conference, and that no action had been taken by Associated Hospital Service, Inc., to date. Upon motion by Pippin–Bowen, the matter was referred to the Executive Committee of the Council with an expression of opinion that it hold such final conferences with the Associated Hospital Service, Inc., as it deemed advisable, and that the then final recommendation of the Executive Committee be referred, by mail ballot, to the Council for approval.

7. Racine County Medical Society Problems

A delegation from the Racine County Medical Society appeared before the Council consisting of Dr. Beatrice O. Jones and Dr. E. J. Schneller, secretary and president of that society, respectively.

(A) Contract Practice: Dr. Jones discussed the matter of proposed contract practice in Racine involving retention of one physician by an industrial plant to do all surgery and with an arrangement for insurance coverage by one carrier, combined on the other hand with an agreement to provide all medical care for a bid price per year. The implications of such an arrangement were presented and advice of the Council sought. Vice-speaker Kurten (Racine) amplified the discussion.

There was further discussion by Councilors Krahn, Gavin, Clark, Gramling, Fitzgerald, Butler and Bowen, Vice-speaker Kurten, Past-president Rector, Secretary Crownhart, Assistant Secretary Larson, and Dr. Jones of Racine.

It was moved by Fitzgerald–Krahn that the physicians in Racine be advised of Sections 2 and 3 of Article VI of the Principles of Ethics of the American Medical Association, and that they be advised that the Council of the State Medical Society will consider violations to be matters of the utmost seriousness. Carried unanimously.

(B) Illegal Cult Practices: Dr. Jones discussed difficulties experienced in Racine involving a cultist who apparently was alleged to be practicing medicine and dispensing drugs. There was discussion by Councilors Pechous, Christofferson, Gramling, Krahn, Clark, Butler, Pippin, Lambert and Gavin; Dr. Jones; Vice-speaker Kurten; Delegate Sargent; and Mr. Kelley. It was moved by Krahn–Gramling that the Committee on Public Policy be instructed to proceed with the drafting of proper legislation. Carried unanimously.

8. Amendments to By-Laws

Secretary Crownhart presented and discussed proposed amendments to the By-Laws, for submission to the 1940 House of Delegates. These amendments appear on page 646 of this issue of The Journal.

It was moved by Krahn–Johnson that the amendments be adopted for submission to the House of Delegates. Carried unanimously.

9. Badge to Honor Fifty Years' Service

Secretary Crownhart explained the proposal of the Society adopting a policy of awarding a badge to every physician who has served his profession and the public for fifty years, the costs involved, etc., and asked the wishes of the Council. There was discussion by Councilors Gavin, Krahn and Johnson, and Secretary Crownhart.

It was moved by Councilor Bowen that the length of practice involved be reduced from fifty years to forty years. There was no second.

It was moved by Krahn–Bowen that the entire matter be laid on the table. Carried unanimously.

10. Use of the Word "Clinic"

Secretary Crownhart explained this matter was referred to the executive office by a member with later correspondence with the American Medical Association, and implications arising in connection with malpractice insurance carriers. No action was taken by the Council on the matter.

11. Resolutions Adopted at the 1940 Convention of the American Medical Association

Secretary Crownhart read the following reports relative to hospital care insurance, which were adopted by the American Medical Association in New York in June, 1940:

I. "The appropriation by hospitals of the services of the physician both clinical and laboratory is to be deplored and if allowed to continue and develop will threaten the future of medicine and endanger the welfare of the public. It is high time that the medical profession through its state and county societies assert its rights in no uncertain terms regarding these abuses. The ten principles adopted by the House of Delegates in 1937 and revised and reaffirmed in 1938 provide that hospital service insurance should not include any type of medical care and we again stress the importance of this declaration."

II. "Your committee also recommends that the House of Delegates reaffirm the principles pertaining to medical service plans previously adopted and urges the acceptance and application by all medical societies of the principles that prepayment group medical arrangements shall be controlled by the medical profession and that medical services be excluded from all group hospitalization plans, but that, if the inclusion of special medical services are deemed necessary, the cost of such services be paid for in cash by the group hospitalization corporation directly to the insured persons."

There was discussion by Councilors Butler and Gavin.

The meeting adjourned at 4:00 p.m.

J. G. Crownhart,
Secretary.

Approved:

Stephen E. Gavin, M. D.,
Chairman of the Council.

SYNTHETIC RUBBER GLOVES AVAILABLE FOR TRIAL

A firm manufacturing synthetic rubber gloves which are claimed to bring relief from dermatitis caused by an allergen in natural rubber has offered to furnish information and a pair of gloves for trial to a physician suffering from this sort of dermatitis. Any member of the Society interested in the offer may obtain a sample pair of gloves by writing the State Medical Society of Wisconsin, 917 Tenney Bldg., Madison.

Preliminary Program Announced For Ninety-Ninth Anniversary Meeting

Industrial Health to Be Main Keynote; Personal Military Problems to Be Stressed

View of downtown Milwaukee, convention city.

THE Council on Scientific Work announces that in cooperation with the Committee on Industrial Health the subjects of industrial health and industrial medicine will be emphasized at the ninety-ninth anniversary meeting to be held in the main arena of the Milwaukee Auditorium. There will be a distinct correlation between the scientific program and the scientific exhibits. Over two-thirds of the available scientific exhibits will be devoted to the subject of industrial medicine.

While the main emphasis in the general sessions will be placed on the subjects of industrial medicine and medical-military problems, Thursday morning is set aside for the several sections of the Society. The sections offering special programs are those on medicine, surgery, obstetrics and gynecology, pediatrics, otolaryngology, ophthalmology, and radiology.

The Council on Scientific Work recognizes that with the possible imminence of mobilization, many professional and personal problems arise. The military portion of the scientific program is divided into two phases. The first phase relates to some of the scientific aspects of modern military combat, and the second is devoted to personal problems confronting the physician in private practice. The Society is indeed fortunate in having secured as one of the speakers on the program Dr. W. M. Boothby of the Mayo Clinic, professor of medicine and biochemistry of the University of Minnesota Graduate School. His subject for discussion before the general session on Friday is "Physiologic Problems Involved in Aviation; Anoxemia and Its Prevention."

The second phase of the military portion of the program includes such speakers as Brigadier General Ralph M. Immell, the adjutant general of Wisconsin, and others outstanding in the military field. Since there are many problems of a more or less per-

sonal nature which physicians may not wish to discuss in a large meeting, three round-table luncheons on military subjects have been planned wherein the attendance will be limited to twenty and the individual physician need not hesitate to raise personal questions with respect to possible mobilization. These round-table luncheons will be conducted by Major L. W. Peterson, commanding officer, third battalion, 135th medical regiment, Sun Prairie; Major Eben J. Carey, intelligence planning and training officer, 135th medical regiment (dean, Marquette University School of Medicine, Milwaukee); and Lieutenant Colonel W. J. Bleckwenn, executive officer, 135th medical regiment (professor of neuropsychiatry, University of Wisconsin Medical School, Madison).

Photography is playing an increasingly important role in the preparation and maintenance of case histories, consequently arrangements have been made to have available in the exhibit hall an educational photographic exhibit. This exhibit will be in charge of one of the members of the research staff of the Eastman Kodak Company, and will provide a means whereby individual members of the Society may secure answers to photographic problems arising in the preparation of case histories. The technics for recording by means of still cameras and by motion picture cameras will be explained on an individual basis by the representative in attendance. This is strictly an educational exhibit and is an effort by the Society to assist members in solving medical photographic problems.

Dr. C. J. Smiles of Ashland, the member of the Council on Scientific Work directly in charge of the program arrangements, has secured the following outstanding medical scientists and practitioners from outside the State:

A. J. Lanza, Metropolitan Life Insurance Company, New York City, New York.

Chester Keefer, director, Robert Dawson Evans Memorial Hospital, Boston, Massachusetts; associate professor of medicine, Harvard Medical School, and Wade professor of medicine, Boston University School of Medicine.

Lee Foshay, professor of bacteriology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

F. J. Hirschboeck, Duluth Clinic, Duluth, Minnesota.

E. G. Billings, assistant professor of psychiatry, University of Colorado School of Medicine, Denver, Colorado.

Arthur R. Elliott, clinical professor of medicine, Rush Medical College, University of Chicago, Chicago, Illinois.

Grover Penberthy, professor of clinical surgery, Wayne University College of Medicine, Detroit, Michigan.

Edwin F. Daily, Children's Bureau, U. S. Department of Labor, Washington, D. C.

John L. McKelvey, professor of obstetrics and gynecology, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis, Minnesota.

Charles E. Galloway, assistant professor of obstetrics and gynecology, Northwestern University Medical School, Chicago; Evanston, Illinois.

Gerald M. Cline, Bloomington, Illinois.

John A. Bigler, assistant professor of pediatrics, Northwestern University Medical School, Chicago; Highland Park, Illinois.

Gordon B. New, professor of otolaryngology and rhinology, University of Minnesota Graduate School, Minneapolis–Rochester; The Mayo Clinic, Rochester, Minnesota.

George E. Shambaugh, Jr., associate clinical professor of otology and laryngology, Rush Medical College, University of Chicago, Chicago, Illinois.

Peter C. Kronfeld, dean of instruction, The Illinois Eye and Ear Infirmary, Chicago, Illinois.

F. Bruce Fralick, professor of ophthalmology, University of Michigan Medical School, Ann Arbor, Michigan.

Franklin G. Ebaugh, professor of psychiatry, University of Colorado School of Medicine, Denver, Colorado.

W. A. Fansler, clinical associate professor of surgery, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis, Minnesota.

Samuel H. Boyer, Jr., Duluth, Minnesota.

C. C. Higgins, Cleveland Clinic, Cleveland, Ohio.

Fred E. B. Foley, clinical associate professor of urology, University of Minnesota Medical School, and clinical associate professor of surgery, University of Minnesota Graduate School, Minneapolis; St. Paul, Minnesota.

James Evans, Lahey Clinic, Boston, Massachusetts.

E. L. Jenkinson, associate professor of radiology, Northwestern University Medical School, Chicago, Illinois.

W. M. Boothby, professor of medicine and biochemistry, University of Minnesota Graduate School, Minneapolis–Rochester; The Mayo Clinic, Rochester, Minnesota.

Kellogg Speed, clinical professor of surgery, Rush Medical College, University of Chicago, Chicago.

PROGRAM SYNOPSIS

TUESDAY, SEPTEMBER 17

P. M.
6:30—House of Delegates—Banquet Room (Fifth Floor), Schroeder Hotel

WEDNESDAY, SEPTEMBER 18

A. M.
8:00—Registration—Main Arena, Milwaukee Auditorium
9:15—General Session — Plankinton Hall (Second Floor)
10:00—Recess to view exhibits
10:20—General Session — Plankinton Hall (Second Floor)

P. M.
2:00—General Session — Plankinton Hall (Second Floor)
3:20—Recess to view exhibits
3:40—General Session — Plankinton Hall (Second Floor)
6:30—House of Delegates—Pere Marquette Room (Fifth Floor), Schroeder Hotel
8:30—Smoker — Crystal Ballroom (Fifth Floor), Schroeder Hotel

THURSDAY, SEPTEMBER 19

A. M.
8:00—House of Delegates—Banquet Room (Fifth Floor), Schroeder Hotel
Section meetings:
8:30—Otolaryngology—Juneau Hall North (First Floor)
9:00—Medicine—Plankinton Hall (Second Floor)
9:00—Obstetrics and Gynecology—Walker Hall (First Floor)
9:00—Radiology—Committee Room D (Second Floor)
9:00—Surgery—Engelmann Hall (Second Floor)
9:15—Pediatrics — South Kilbourn Hall (First Floor)

P. M.
12:10—Round-Table Luncheons — Schroeder Hotel
2:00—Section on Ophthalmology—Juneau Hall North (First Floor)
2:15—General Session — Plankinton Hall (Second Floor)
3:30—Recess of General Session to view exhibits
3:50—General Session — Plankinton Hall (Second Floor)
6:45—Annual Dinner — Crystal Ballroom, Schroeder Hotel

FRIDAY, SEPTEMBER 20

A. M.
9:20—General Session — Plankinton Hall (Second Floor)
10:20—Recess to view exhibits
10:40—General Session — Plankinton Hall (Second Floor)

P. M.
12:10—Round-Table Luncheons — Schroeder Hotel
2:15—General Session — Plankinton Hall (Second Floor)

Air view of Milwaukee, business and industrial section.

TUESDAY EVENING, SEPTEMBER 17

P. M.
6:30 House of Delegates—Banquet Room (Fifth Floor), Schroeder Hotel

The keynote of this program is industrial health and the subjects related to that theme

WEDNESDAY, SEPTEMBER 18

A. M.
8:00 Registration, Main Arena, Milwaukee Auditorium
9:15 General Session, Plankinton Hall (Second Floor)
9:15 Tuberculosis Case Finding in Industry
O. A. Sander, Milwaukee
9:35 Silicosis with Special Reference to Wisconsin Industry
A. J. Lanza, Metropolitan Life Insurance Company, New York City, New York
10:00 Recess to view exhibits

Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:20 Cardiovascular Disease in Industry
W. J. Egan, assistant clinical professor of medicine, Marquette University School of Medicine, Milwaukee
10:40 Industrial Dermatoses
Harry R. Foerster, assistant professor of dermatology, University of Wisconsin Medical School, Madison, and assistant clinical professor of dermatology, Marquette University School of Medicine, Milwaukee
11:00 Industrial Health
Paul Brehm, supervisor, Industrial Hygiene Unit, State Board of Health, Madison

A. M.

11:20 Program of the State Industrial Commission for Physical Examinations in Industry

Mr. H. A. Nelson, director, Workmen's Compensation, Industrial Commission of Wisconsin, Madison

11:40 Expediting Insurance Claims by Cooperation with Insurance Companies

Mr. Reuben G. Knutson, assistant claims manager in charge of compensation, Hardware Mutual Casualty Insurance Company, Stevens Point

P. M.

This afternoon's program is arranged to emphasize points in industrial surgery

2:00 Congenital Developmental and Acquired Characteristics of the Spine and Their Relation to Injuries—Lantern Slides

Merritt L. Jones, Wausau

2:30 First Aid in Fractures—Lantern Slides

Herman C. Schumm, associate professor of orthopedic surgery, University of Wisconsin Medical School, Madison, and clinical professor of orthopedic surgery, Marquette University School of Medicine, Milwaukee

2:50 Fractures About the Ankle — Lantern Slides

Walter P. Blount, Milwaukee

3:10 Fractures About the Wrist — Lantern Slides

Henry L. Greene, Madison

3:20 Recess to view exhibits

3:40 Treatment of Burns

A. A. Schaefer, Milwaukee

4:00 Some Common Every Day Injuries Around the Knee Joint

Kellogg Speed, clinical professor of surgery, Rush Medical College, University of Chicago, Chicago

P. M.

6:30 House of Delegates—Pere Marquette Room (Fifth Floor), Schroeder Hotel

8:30 Smoker—Crystal Ballroom (Fifth Floor), Schroeder Hotel

MARQUETTE MEDICAL ALUMNI LUNCHEON

The annual Marquette Medical Alumni Luncheon will be held in the Schroeder Hotel on Wednesday, September 18, at 12:15 p. m.

THURSDAY, SEPTEMBER 19

A. M.

8:00 House of Delegates—Banquet Room (Fifth Floor), Schroeder Hotel

SECTION ON OTOLARYNGOLOGY

Juneau Hall North (First Floor)

T. F. McCormick, assistant clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee, chairman

A. M.

8:30 Acute Laryngotracheal Bronchitis

W. J. Troup, Green Bay

Discussant:

8:55 N. S. Simons, Whitehall

9:05 Surgical Treatment of Otosclerosis

George E. Shambaugh, Jr., associate clinical professor of otology and laryngology, and chairman of the Department of Otology and Laryngology, Rush Medical College, University of Chicago, Chicago, Illinois

Discussant:

9:40 Wellwood M. Nesbit, professor of otolaryngology, University of Wisconsin Medical School, Madison

10:00 Recess to view exhibits

10:20 Early and Late Treatment of Traumatic Injuries of the Face

Gordon B. New, professor of otolaryngology and rhinology, University of Minnesota Graduate School, Minneapolis–Rochester; The Mayo Clinic, Rochester, Minnesota

Discussant:

10:55 Matthew Federspiel, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

11:05 Vertigo

W. E. Grove, clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee

Discussant:

11:35 J. K. Trumbo, Wausau

NORTHWESTERN UNIVERSITY ALUMNI LUNCHEON

12:00 Noon, Wednesday, September 18, Schroeder Hotel

Guest speaker: Walter H. Nadler, M.D., president of the Medical Division of the Alumni Association (associate professor of medicine, Northwestern University Medical School, Chicago).

Committee in charge: D. E. W. Wenstrand, M.D., V. F. Lang, M.D., and R. H. Feldt, M.D., all of Milwaukee.

SECTION ON MEDICINE

Plankinton Hall (Second Floor)

O. O. Meyer, associate professor of medicine, University of Wisconsin Medical School, Madison, chairman

A. M.

9:00 The Treatment of Advanced Portal Cirrhosis
John A. Schindler, Monroe
Discussant:
9:20 Karl H. Doege, Marshfield

9:30 Some Aspects of the Treatment of Acute and Chronic Arthritis
Chester Keefer, director, Robert Dawson Evans Memorial Hospital, Boston, Massachusetts; associate professor of medicine, Harvard Medical School, and Wade professor of medicine, Boston University School of Medicine

10:00 Polycythemia
A. A. Holbrook, Milwaukee
Discussant:
10:20 Chester Keefer, Boston

10:30 Recess to view exhibits

11:00 Calcareous Aortic Stenosis
W. A. Killins, Green Bay
Discussants:
11:20 Charles Burke, Madison
11:25 F. J. Hirschboeck, Duluth, Minnesota

11:30 The Diagnosis of Brucellosis
Lee Foshay, professor of bacteriology, University of Cincinnati College of Medicine, Cincinnati, Ohio

SECTION ON OBSTETRICS AND GYNECOLOGY

Walker Hall (First Floor)

Roland S. Cron, clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

A. M.

9:00 Occult Hypothyroidism in Wisconsin Women
Addie M. Schwittay, Madison

9:20 Maternal Care and Maternal Mortality
Edwin F. Daily, Children's Bureau, United States Department of Labor, Washington, D. C.; instructor in department of obstetrics and gynecology, University of Chicago (on leave of absence)
Discussant:
9:40 John W. Harris, professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

9:50 Recess to view exhibits

A. M.

10:10 Management of the Third Stage of Labor
Charles J. Newcomb, Milwaukee
Discussant:
10:30 Henry J. Olson, assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

10:40 Irregular Shedding and Regeneration of the Endometrium as a Clinical and Diagnostic Problem
John L. McKelvey, professor of obstetrics and gynecology, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis, Minnesota
Discussant:
11:00 G. H. Hansmann, Milwaukee

11:10 Lantern Demonstrations of Cervical Lesions of the Uterus
Charles E. Galloway, assistant professor of obstetrics and gynecology, Northwestern University Medical School, Chicago; Evanston, Illinois
Discussant:
11:30 Harold W. Shutter, Milwaukee

SECTION ON RADIOLOGY

Committee Room D (Second Floor)

T. J. Pfeffer, Racine, chairman

9:00 A Case Report
H. W. Hefke, Milwaukee

9:15 A Case Report
W. T. Clark, Janesville

9:30 Photofluoroscopy and Roentgenography as Used at the Wisconsin State Sanatorium
H. M. Coon, Statesan

9:50 A Case of Bone Metastases
L. V. Littig, Madison

10:05 A Case Report
F. H. Kuegle, Janesville

10:20 Recess to view exhibits

> The technical exhibits make it possible to present the annual meeting without a registration fee. Express your appreciation to the exhibitors by visiting their booths.

10:40 A Gastro-Intestinal Case Report
I. G. Ellis, Madison

10:55 Cholangiography
I. I. Cowan, Milwaukee

11:10 A Surgical Case Report
R. P. Potter, Marshfield

11:25 A Therapeutic Case Report
E. A. Pohle, professor of radiology, University of Wisconsin Medical School, Madison

11:40 Diaphragmatic Hernia
S. A. Morton, Milwaukee

SECTION ON SURGERY

Engelmann Hall (Second Floor)

As the surgical case is often, at some time, a medical problem, and as we have passed, chronologically speaking, through the "Technical Thirties" and have entered the "Physiological Forties," this program will consider certain fundamental principles of diagnosis and treatment instead of designated disease, trauma, or technical details.

The first half of this sectional program is devoted to diagnosis and the second half to treatment.

F. Gregory Connell, Oshkosh, chairman

Diagnosis

Extra-abdominal diseases that may cause abdominal symptoms

A. M.

9:00 Neuropsychiatric Diseases
E. G. Billings, assistant professor of psychiatry, University of Colorado School of Medicine, Denver, Colorado

9:20 Cardiovascular-renal and Pulmonary Diseases
Arthur R. Elliott, clinical professor of medicine, Rush Medical College, University of Chicago, Chicago, Illinois

9:40 Miscellaneous Diseases (Allergy; Endocrine, Hormonal, and Hematologic; Vitamins, etc.)
F. W. Madison, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee

Discussants:

10:00 Carl Eberbach, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

10:10 J. W. Gale, associate professor of surgery, University of Wisconsin Medical School, Madison

10:20 Recess to view exhibits

Treatment

Preoperative and Postoperative Management

P. M.

10:30 In Shock and Hemorrhage
Carl Williamson, Green Bay

Discussants:

10:50 Stanley J. Seeger, Milwaukee

11:00 Sigurd Gundersen, La Crosse

11:10 In Peritonitis and Ileus
Grover Penberthy, professor of clinical surgery, Wayne University College of Medicine, Detroit, Michigan

Discussants:

11:30 E. H. Mensing, Milwaukee

11:40 M. E. Gabor, Milwaukee

Lake shore view, Milwaukee.

SECTION ON PEDIATRICS

South Kilbourn Hall (First Floor)

H. Kent Tenney, associate professor of pediatrics, University of Wisconsin Medical School, Madison, chairman

A. M.

9:15 Encephalography in Children; Indications and Interpretations
M. G. Peterman, Milwaukee

Discussant:

9:35 L. M. Simonson, Sheboygan

9:40 The Problem of Squint in Young Children
E. E. Neff, associate professor of ophthalmology, University of Wisconsin Medical School, Madison

Discussant:

10:00 H. Kent Tenney, Madison

10:05 Recess to view exhibits

10:25 Allergy in Children with Special Reference to Infantile Eczema
Gerald M. Cline, Bloomington, Illinois

Discussant:

10:45 F. R. Janney, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee; Wauwatosa

10:55 Treatment of Pneumonia in Children, with Sulfapyridine
John A. Bigler, assistant professor of pediatrics, Northwestern University Medical School, Chicago; Highland Park, Illinois

Discussant:

11:25 J. M. Freeman, Wausau

11:35 Management of the Premature Infant
H. O. McMahon, clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee

Discussant:

11:55 H. E. Van Riper, Madison

The building which will house the scientific sessions of the 1940 annual meeting of the State Medical Society,—The Milwaukee Auditorium.

12:10 ROUND TABLE LUNCHEONS

Schroeder Hotel

1. Bedside Medicine and New Drugs
   James Evans, Boston, Massachusetts
   Parlor A, Fourth Floor
2. Bedside Medicine and New Drugs
   F. W. Madison, Milwaukee
   Parlor B, Fourth Floor
3. Treatment of Acute Episodes in Medical Practice
   Francis Murphy, clinical professor of medicine, Marquette University School of Medicine, Milwaukee
   Parlor C, Fourth Floor
4. Do-Nots in Office Proctology
   W. A. Fansler, clinical associate professor of surgery, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis, Minnesota
   Parlor D, Fourth Floor
5. The Use of Vitamins in Ophthalmology
   Peter C. Kronfeld, dean of instruction, The Illinois Eye and Ear Infirmary, Chicago, Illinois
   Parlor E, Fourth Floor
6. Ocular Allergy
   F. Bruce Fralick, professor of ophthalmology, University of Michigan Medical School, Ann Arbor, Michigan
   Parlor F, Fourth Floor
7. Prevention and Treatment of Tetanus
   John A. Bigler, Highland Park, Illinois
   Parlor G, Fourth Floor
8. The Prevention and Treatment of Vomiting of Pregnancy
   Madeline Thornton, assistant professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison
   Parlor H, Fourth Floor
9. Infectious Diseases
   Lee Foshay, Cincinnati, Ohio
   Parlor I, Fourth Floor
10. Nutritional Diseases With Special Reference to the Vitamin Deficiencies
    Harold Marsh, Madison
    Committee Room, Fifth Floor
11. Intestinal Obstruction; Its Clinical Management
    E. R. Schmidt, professor of surgery, University of Wisconsin Medical School, Madison, and Grover Penberthy, Detroit, Michigan
    Pere Marquette Room, Fifth Floor
12. Personality Reactions Following Lower Abdominal Surgery in Women
    E. G. Billings, Denver, Colorado
    English Room, Fifth Floor
13. X-ray Treatment of Brain Tumors
    E. L. Jenkinson, associate professor of radiology, Northwestern University Medical School, Chicago, Illinois
    Pine Room, Fifth Floor
14. Treatment of Chronic Suppurative Otitis Media
    George E. Shambaugh, Jr., Chicago, Illinois
    Room B, Fifth Floor
15. Deep Infections of the Neck
    Gordon B. New, Rochester, Minnesota
    Room C, Fifth Floor
16. Some Newer Concepts of Premature Separation of the Normally Implanted Placenta
    John McKelvey, Minneapolis, Minnesota
    Room D, Fifth Floor
17. Treatment of Arthritis
    Chester Keefer, Boston, Massachusetts
    Room E, Fifth Floor
18. Discussion of Personal Problems Should M-Day Become an Actuality
    Major L. W. Peterson, commanding officer, third battalion, 135th medical regiment, Sun Prairie
    Room F, Fifth Floor

19. Management of Urinary Tract Infections
C. C. Higgins, Cleveland, Ohio
Lounge Section of Banquet Room, Fifth Floor

20. Analgesia and Anesthesia in Labor
Charles E. Galloway, Evanston, Illinois
Room 619, Sixth Floor

SECTION ON OPHTHALMOLOGY

Juneau Hall North (First Floor)

Mark E. Nesbit, Madison, chairman

P. M.

2:00 The Pharmacology of Paradine and Prostigmine
R. O. Ebert, Oshkosh
Discussant:
2:25 A. H. Pember, Janesville

2:35 Uveitis with Secondary Glaucoma
F. Bruce Fralick, Ann Arbor, Michigan
Discussant:
3:05 Clarence K. Schubert, Madison

3:15 Recess to view exhibits

3:55 The Practical Value of Gonioscopy for the Understanding, Diagnosis, and Treatment of Glaucoma
Peter C. Kronfeld, Chicago, Illinois
Discussant:
4:10 G. L. McCormick, Marshfield

GENERAL SESSION

Plankinton Hall (Second Floor)

P. M.

2:15 Our Mental Health
(Rogers Memorial Lecture)
Franklin G. Ebaugh, professor of psychiatry, University of Colorado School of Medicine, Denver, Colorado

2:50 Surgical Treatment of Hemorrhoids
W. A. Fansler, Minneapolis, Minnesota

3:10 Lesions of the Diaphragm (Diaphragmatic Hernia, Congenitally Short Esophagus, Thoracic Stomach, and Absence of the Diaphragm)
E. L. Jenkinson, Chicago, Illinois

3:30 Recess to view exhibits

3:50 The Present Status of Chemotherapy in the Treatment of Infectious Diseases
Chester Keefer, Boston, Massachusetts

4:10 Secretary's Report
Mr. J. G. Crownhart, secretary, State Medical Society of Wisconsin

4:20 Common Pitfalls in Diagnosis
Frank Hirschboeck, Duluth, Minnesota

4:40 Arteriosclerotic Toxemia of Pregnancy
John L. McKelvey, Minneapolis, Minnesota

P. M.

6:45 Annual Dinner—Crystal Ballroom, Schroeder Hotel (Informal)
Speaker: Dr. Eben J. Carey, Milwaukee

FRIDAY, SEPTEMBER 20

GENERAL SESSION

Plankinton Hall (Second Floor)

A. M.

9:20 Clinical Aspects of Bronchogenic Carcinoma
George C. Owen, Oshkosh

9:40 Prostatic Resection; Some Facts and Fancies Revealed by Time
James C. Sargent, clinical professor of urology, Marquette University School of Medicine, Milwaukee

10:00 President's Address
R. P. Sproule, Milwaukee

10:20 Recess to view exhibits

> This time is set aside to give you an opportunity to visit the technical and scientific exhibits. Please stop in and see them.

10:40 The Internist and Acute Disease of the Abdomen
Samuel H. Boyer, Jr., Duluth, Minnesota

11:00 Management of Patients with Renal Lithiasis
C. C. Higgins, Cleveland, Ohio

11:30 Hydronephrosis
Fred E. B. Foley, clinical associate professor of urology, University of Minnesota Medical School, and clinical associate professor of surgery, University of Minnesota Graduate School, Minneapolis; St. Paul, Minnesota

12:10 ROUND TABLE LUNCHEONS

Schroeder Hotel

1. Preventable Factors in Maternal Mortality
Edwin F. Daily, Washington, D. C.
Parlor A, Fourth Floor

2. Choice of Operation for Viscal Neck Obstruction
Fred E. B. Foley, St. Paul, Minnesota
Parlor B, Fourth Floor

3. Preferable Techniques in Taking X-ray Films of the Chest, Their Interpretation and Interesting Cases
A. A. Pleyte, assisted by S. A. Morton, Milwaukee
Parlor C, Fourth Floor

4. The Newer Drugs; Clinical Use of Sulfanilamide and Its Allies
Francis Murphy, Milwaukee
Parlor D, Fourth Floor

5. Diagnosis and Treatment of Hemorrhagic Diseases
   A. J. Quick, associate professor of pharmacology, Marquette University School of Medicine, Milwaukee
   Parlor E, Fourth Floor
6. Industrial Medicine With Special Reference to the Effects of Toxic Dusts and Solvents
   Elston Belknap, assistant clinical professor of medicine, Marquette University School of Medicine, Milwaukee
   Parlor F, Fourth Floor
7. Allergy and Dermatology
   T. L. Squier, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee, and Harry R. Foerster, Milwaukee
   Parlor G, Fourth Floor
8. The Uses and Abuses of Pituitary Extract in Obstetrics
   John W. Harris, Madison
   Parlor H, Fourth Floor
9. Orthopedics and the General Practitioner
   R. M. Carter, Green Bay
   Parlor I, Fourth Floor
10. Surgery of the Biliary System
    S. E. Gavin, Fond du Lac
    Committee Room, Fifth Floor
11. Care of the Cardiac Cripple During Childhood and Adolescence
    Maurice Hardgrove, Milwaukee
    Pere Marquette Room, Fifth Floor
12. Bedside Medicine and New Drugs
    James Evans, Boston, Massachusetts
    English Room, Fifth Floor
13. Arthritis; the Wisconsin Rheumatism Association Has Something to Tell
    M. C. Borman, Millard Tufts, and W. J. Egan, Milwaukee
    Pine Room, Fifth Floor
14. Discussion of Personal Problems Should M-Day Become an Actuality
    Major Eben J. Carey, intelligence planning and training officer, 135th medical regiment (dean, Marquette University School of Medicine, Milwaukee)
    Room B, Fifth Floor

Schroeder Hotel; headquarters hotel, 1940 annual session of the State Medical Society.

15. Discussion of Personal Problems Should M-Day Become an Actuality
    Lieutenant Colonel W. J. Bleckwenn, executive officer, 135th medical regiment (professor of neuropsychiatry, University of Wisconsin Medical School, Madison)
    Room C, Fifth Floor

GENERAL SESSION

Plankinton Hall (Second Floor)

P. M.

2:15 Surgical Significance of Jaundice in Infants and Children
Stanley J. Seeger, Milwaukee

2:35 Physiologic Problems Involved in Aviation; Anoxemia and Its Prevention
W. M. Boothby, professor of medicine and biochemistry, University of Minnesota Graduate School, Minneapolis–Rochester; The Mayo Clinic, Rochester, Minnesota

2:55 A medical-military subject to be announced later
Colonel Fred T. Cruse, field artillery, United States Army

3:05 A medical-military subject to be announced later
Brigadier General Ralph M. Immell, the adjutant general of Wisconsin

HOTEL RESERVATIONS

Have you made hotel reservations to assure obtaining accommodations when you reach Milwaukee for the annual meeting? If you have not, it is suggested that you write the hotel of your choice at once for a reservation.

Scientific Exhibits

BOOTHS 1, 2, 3 AND 4

Cooperative Medical and Engineering Effort in Industrial Health

E. G. Meiter, Ph.D., Industrial Hygiene Department, Employers Mutuals; E. L. Belknap. Milwaukee; O. A. Sander, Milwaukee; Norbert Enzer, Milwaukee; Mr. W. A. Vollmer, Milwaukee

This exhibit will be a cooperative effort featuring both medical and engineering methods for the control of health and safety of industrial workers. Medical aspects will feature the Wisconsin Physical Examination Program as sponsored by the Industrial Commission. In addition, x-ray films illustrating both silicotic and non-silicotic lungs will be shown. There will also be on display, lung specimens showing silicosis, anthracosis, siderosis, and asbestosis. Lead as a toxic dust will be treated from both the standpoint of treatment and prevention of poisoning.

Engineering control of occupational diseases will be illustrated by instruments and devices used for measuring and eliminating the toxic agents in air. The accident prevention phases of the problem will be devoted primarily to an exhibition of model dies designed for the elimination of punch press accidents. An exhibit of various types of safety clothing will be included.

BOOTH 5

Health for Industry by Industry

Committee on Healthful Working Conditions, National Association of Manufacturers

The exhibit of the Committee on Healthful Working Conditions of the National Association of Manufacturers portrays the broad approach to the problem of industrial health work, as well as interesting details essential to a consideration of employe health work. In addition, typical results of good company health programs are presented to demonstrate what may be expected from an efficient program to improve employe health.

BOOTH 6

Sick Absenteeism Recording

P. A. Neal, National Institute of Health, United States Public Health Service

This exhibit has been prepared by the Division of Industrial Hygiene (Acting Chief, Dr. P. A. Neal) for the purpose of acquainting the medical profession, first, with the importance to labor, management and preventive medicine of the recording of absenteeism among industrial workers, and, second, with a practical plan believed to yield useful records.

The exhibit presents the three forms necessary for the recording of absences according to the plan proposed, and, with the use of charts based on industrial morbidity experiences, the justification for recording data on absenteeism.

BOOTHS 7 AND 8

Artificial Air for Use by Pressure Workers

Edgar End, Department of Physiology, Marquette University School of Medicine

Medical research has made possible every major advance during the past half century in the field of pressure work. This exhibit deals particularly with the development of artificial helium-oxygen breathing mixtures for use under increased atmospheric pressure. These mixtures have already made possible a new world record for deep diving and have been adopted by the United States Navy. Their development is the result of applying medical knowledge to an important industrial problem. The exhibit includes the diving suit in which the present world record was established and other recently developed equipment for use under increased atmospheric pressure.

BOOTH 9

Milkers' Nodules

F. T. Becker, Duluth, Minnesota

This exhibit shows illustrations of four typical cases of milkers' nodules. Pathology of various stages of the infection, diagnostic criteria and differential diagnosis are demonstrated.

BOOTH 10

Wisconsin Rheumatism Association

M. C. Borman, Milwaukee

This exhibit stresses the importance of early differential diagnosis in the management of rheumatism. X-ray studies of the hand, based upon the work of Scott, are presented. Examples of rheumatoid arthritis, osteoarthritis, infective and gouty arthritis are shown, with x-ray films and case histories.

Interpretation of x-ray pictures is presented according to the following form.

1. Decalcification (systemic—regional—local)
2. Bone production (lipping—osteophytes)
3. Bone destruction (active—atrophic)
4. Joint space
5. Ankylosis (bony—fibrous)
6. Changes in soft tissue (atrophy—swelling—effusion)

Diagnosis: Type of Arthritis

The tremendous importance of the problem of rheumatism is graphically pictured from reports of

the American Committee for the Study of Rheumatism.

An outline of the purpose and objectives of the Wisconsin Rheumatism Association is displayed. Pamphlets stating the aims of the Wisconsin Rheumatism Association will be distributed to those interested.

A question box will be available where questions concerning the management of the rheumatic patient can be deposited.

BOOTHS 11 AND 12

Diseases of the Thyroid Gland

Jackson Clinic

This exhibit will feature: Models and charts on diagnosis and treatment of cretins; maps and charts showing growth of cretinism and distribution of the 500 cases reported in the United States; colored illustrations showing technic of thyroidectomy by electrosurgery for exophthalmic goiter; colored illustrations and models of the various types of goiter, their distinguishing characteristics and the methods of treatment; illustrations, charts and data on hypothyroidism and myxedema illustrating typical and atypical cases, signs, symptoms, methods of treatment and results; moving pictures of cretins and the technic of thyroidectomy.

BOOTHS 13, 14 AND 15

The Pneumoconioses

American Medical Association

The exhibit consists of panels and translight cases which describe the essential facts about benign pneumoconiosis. Simple nodular silicosis, simple conglomerate silicosis, tuberculo-silicosis, and asbestosis.

Publications have been prepared on the etiology and the pathology of pneumoconiosis which will be available on request.

BOOTH 16

Industrial Health in Medical Practice

Council on Industrial Health, American Medical Association

The exhibit consists of charts describing the essential medical factors in industrial health, the present facilities designed to cope with the problems, and other details describing the opportunities open to physicians with proper qualifications in the field of industrial medicine, surgery, and hygiene.

BOOTHS 17, 18 AND 19

Industrial Health Service in Wisconsin

Wisconsin State Board of Health and Wisconsin Industrial Commission

The exhibit material will be composed of field equipment of various kinds for the determination of atmospheric concentrations in industrial environments of various dusts, fumes, vapors and gases.

The exhibit material will be presented as follows:

1. Material from the Industrial Hygiene unit. State Board of Health.
   a. Field equipment for evaluating various industrial health hazards. With this equipment it is possible to collect atmospheric samples of dusts, fumes, vapors and gases in all types of industrial establishments. The equipment will be in operation, showing the sampling procedure.
   b. Equipment and apparatus for making ventilation studies, and such environmental conditions as humidity and temperature.

2. Industrial Commission Exhibit Material
   a. Statistical charts and graphs showing Wisconsin occupational disease experience under the workmen's compensation act over a period of years.
   b. Respiratory protective equipment. The equipment exhibit will include a variety of types suitable for protection against various harmful materials encountered in industry.

BOOTH 20

Lead Absorption and Intoxication in Everyday Life

G. H. Hansmann, and M. C. Perry, M.A.
Columbia Hospital

The exhibit will be a series of transparencies picturing charts, roentgenograms, and photomicrographs representing lead absorption and its consequences in everyday life.

BOOTHS 21 AND 22

Tuberculosis in Industry

Wisconsin Anti-Tuberculosis Association

With the continued reduction in the death rate from tuberculosis, the program for its control must be modified to meet changing conditions. Statistical studies show that tuberculosis is primarily a disease of lower income levels and that men in industry constitute one of the greatest remaining pockets of mortality and morbidity.

Through the use of enlarged spot maps, the exhibit will show the location of deaths from tuberculosis in the Milwaukee area for the key years 1930, 1935 and 1939, centering each year in the more heavily industrialized sections of the city. Charts and posters will also show the relationship of deaths from tuberculosis to various occupational and rental levels.

BOOTH 23

Malaria in the Experimental Laboratory

Harry Beckman and Robert K. Ota, Marquette University School of Medicine

The exhibit will include microscopic slides and live specimens of larvae, pupae, mosquitoes, and canaries to be shown in three divisions as follows:

The asexual stage in the bird:

1. Normal (uninfected) canary blood.
2. Infected canary blood.
   a. before atabrin
   b. after atabrin

The mode of transmission:

1. The rearing of mosquito larvae, pupae and adult mosquitoes.
2. Method of infecting birds or mosquitoes.
3. Apparatus for:
   a. drug administration.
   b. making blood smears.
   c. sporozoite injection.

The sexual cycle in the mosquito:

1. gametocytes.
2. exflagellation.
3. oocysts.
4. sporozoites.

BOOTH 24

A Health Program for Industry Based on a Modern School Hygiene Plan as Seen Through the Eyes Eyes of a Village Health Commissioner

Edwin G. Gute, Commissioner of Health, Villages of Whitefish Bay and Fox Point

The exhibit presents an interesting comparison of two procedures dealing with preventive medicine. An attempt is made to suggest a health program for industry using as a basis experience in administering a modern school hygiene program as practiced in the village of Whitefish Bay.

Many of the public health activities which are at present being conducted in the schools of a highly restricted residential community like Whitefish Bay in order to promote the health of the child can easily be effectively duplicated in industry to improve the health of the worker and the worker's family.

The exhibitor believes we are approaching the time when a greater number of small industrial plants will be served by a larger group of general practitioners sincerely interested and better trained in industrial medicine and hygiene. The medical profession has led the way in this respect as is attested by the fact that for many years general practitioners have been serving as part-time health commissioners and school doctors in small communities throughout the state.

A cursory inspection of this exhibit impresses one almost immediately with the fact that public health and industrial medicine are closely allied.

It is the hope of the exhibitor that many industries both small and large will see the need and realize the advantages to be gained both for the worker as well as the employer by the institution of a health program.

BOOTH 25

Milwaukee Convalescent Serum Center

Columbia Hospital, Milwaukee, Maurice Hardgrove

This exhibit will consist of easily read large graphs showing the results obtained after the use the convalescent sera in the prevention and treatment of certain contagious diseases—scarlet fever, measles, mumps, etc. In addition to this, there will be a demonstration of the preparation of plasma and serum transfusions, as well as some reference to the banking of blood. At the present time, there is tremendous interest in the use of plasma and serum in the treatment of war wounds such as shock and burns, and the attempt will be made to make this exhibit one of current interest.

BOOTH 26

The Diabetic Child

Milwaukee Children's Hospital, George F. Kelly, Nell Clausen, Dietician

The Children's Hospital Exhibit on Diabetes in Children will attempt to show the incidence of this disease, the symptoms, methods of making a diagnosis, and treatment.

Detailed information on diet, such as protein requirement and total calories, will be part of the display together with amounts of carbohydrate, fats, and vitamins necessary in different age groups in children.

The use of insulin will be dealt with in the treatment of coma and control of diabetes.

The routine of the diabetic child in our clinic, the education of the family in diabetic care, and the value of information on disease will receive emphasis in the display.

The exhibitors have been taking four blood sugars during the day once a month on all patients for about two years. Charts showing their blood sugar curves should prove interesting and really tell the variation that may occur in carbohydrate metabolism in diabetic children.

BOOTHS 27 AND 28

Highway Accidents and Alcohol

Committee on Safety on Public Highways

Various forms of testing apparatus will be demonstrated which will give information about reaction time, binocular vision, effect of glare, etc. In addition there will be an actual demonstration of methods of confirming alcoholic intoxication by means of chemical analyses. Harger's method of examining the breath will be featured since speci-

mens can be obtained from visitors and tested within a few minutes. It will be possible to determine the amount of alcohol in the blood at the time of the examination and also to estimate the amount of alcohol recently consumed by the individual.

BOOTH 29

Vital Statistics

Wisconsin State Board of Health

Recent changes in the makeup of birth and death certificates adopted by the Census Bureau at Washington to meet current statistical demands will be made clear in an exhibit offered by the Board's Bureau of Vital Statistics. Certain statistical trends in some of the leading causes of death, past and present, will be presented in graphic form to emphasize marked reductions in deaths due to preventable diseases, and marked increases in certain other diseases associated with older age groups that are commonly referred to as postponable diseases.

BOOTH 30

Maternal and Child Health

Wisconsin State Board of Health

Methods being employed by the State Board of Health to get patients under the care of a physician early in pregnancy, services available to physicians to promote adequate prenatal care, maternal and infant statistics, and other matters involved in the reduction of maternal and infant deaths in Wisconsin will be portrayed in the booth presenting certain phases of the maternal and child health program of the Board. Included in this exhibit will be one of the incubators for the care of prematures recently made available to physicians and hospitals through the Bureau of Maternal and Child Health, as well as a presentation of hospital facilities for obstetrical care available in the state.

BOOTH 31

The Premature Infant Feeding and Nursing Bureau, Inc.

Medical Society of Milwaukee County, James O. Kelley, Executive Secretary

Two years ago the Medical Society of Milwaukee County saw a distinct need for a premature infant feeding and nursing bureau. After surveying the available facilities it was decided that the Visiting Nurse Association of Milwaukee was the best equipped agency to carry on the activities of the Premature Infant Feeding and Nursing Bureau. Due to the many problems which would be confronted by such a project, it was deemed advisable, on the advice of legal counsel, to incorporate this Bureau as a separate corporation.

The purpose of the Premature Infant Feeding and Nursing Bureau is to promote the care and treatment of prematurely born and immature infants; to help in the reduction of infant mortality; to operate and maintain mothers' milk stations for the purpose of supplying breast milk to premature and immature infants; to further the scientific and professional knowledge in regard to the care and treatment of premature and immature infants, and such other business as is incidental and collateral to the said purposes.

During the year of 1939, 16,620¼ ounces or 519½ quarts of milk were secured from eighteen donors who reported to the milk station 996 times in 321 days. This is an average of about fifty visits per donor per year. These donors were paid $1,000.97. This milk was then disposed of in three ways; 6,413½ ounces were sold at the full fee of 10 cents per ounce, 4,814 ounces were sold on a part-fee basis, that is, those people paid what they felt they could afford to pay, and 5,580½ ounces were distributed on a gratis basis, giving a total of 16,808 ounces or 525½ quarts to 132 patients who called at the milk station 833 times for the milk.

This produced an income of $682.15 showing a deficit of $318.82.

During the time that the Bureau has been in operation all the hospitals in the community set up minimum requirements for hospital care of premature infants and minimum requirements for nursing care of prematures.

We believe it is also noteworthy to mention that the Health Commissioner of the City of Milwaukee, in his annual report for the year of 1939, pointed out that the premature mortality rate had been decreased to a considerable extent since The Premature Infant Feeding and Nursing Bureau had been in operation.

BOOTH 32

Medical Library Service

University of Wisconsin Medical School, Gladys Ramsey, Librarian

The Medical Library Service exhibit will explain the extension loan system by which physicians of Wisconsin borrow the latest medical literature at the small cost of postage and packing.

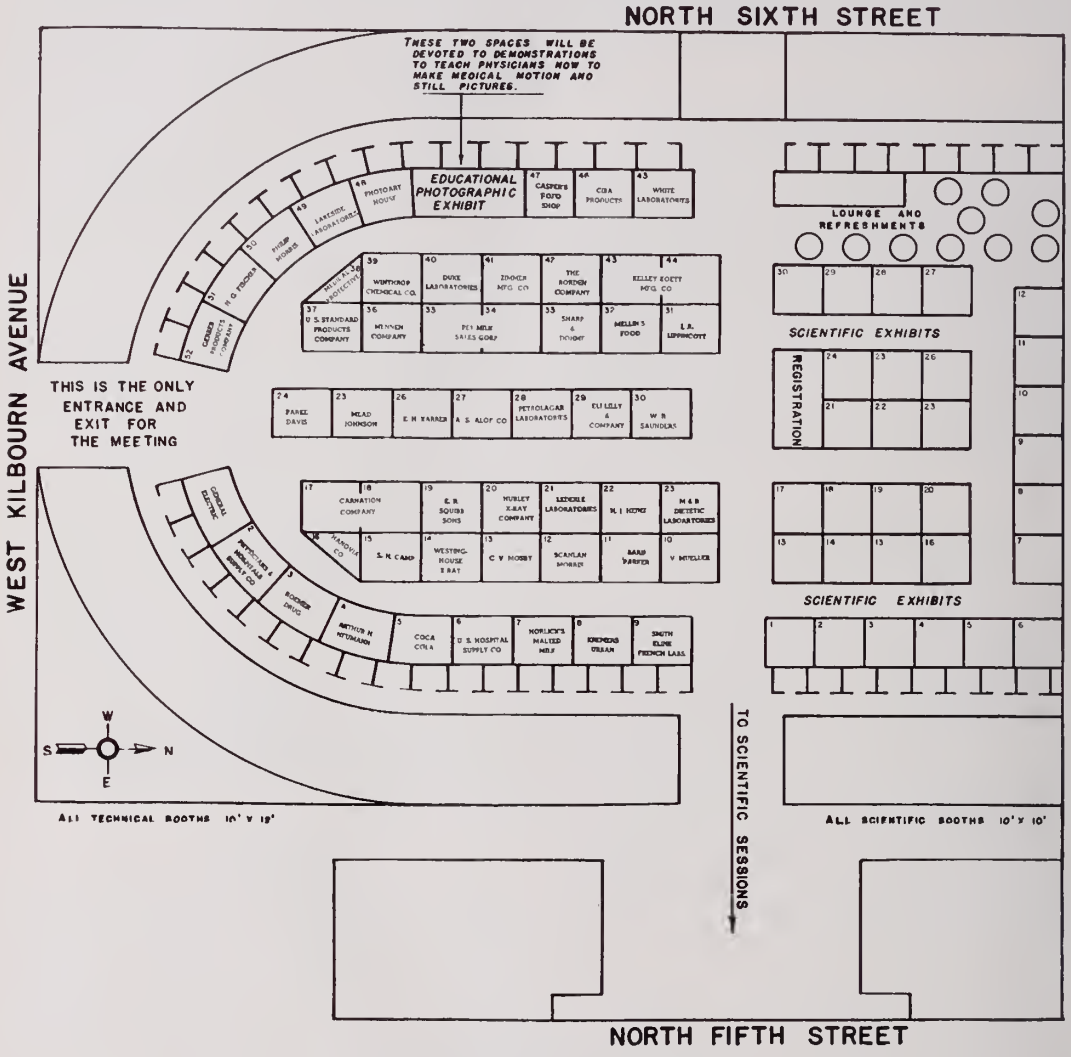
Representative current journals will be shown; the new editions of medical textbooks, some standard reference works, and a few medical histories and biographies will be available for examination. Charts will show the growth and distribution of loans.

New lists of books and journals available and letters explaining the service will be distributed.

PAST PRESIDENTS' LUNCHEON

The annual past presidents' luncheon will be held in the Schroeder Hotel on Wednesday, September 18, at 12:15 p. m.

Floor Plan and Key to Scientific and Technical Exhibits 99th Anniversary Meeting, State Medical Society



KEY TO SCIENTIFIC EXHIBITS

(See detailed description of these exhibits, page 636)

Booth No.	Title	Exhibitor
1— 4	Cooperative Medical and Engineering Effort in Industrial Health	E. G. Meiter, Ph. D., Industrial Hygiene Department, Employers Mutuals; E. L. Belknap, O. A. Sander and Norbert Enzer, Milwaukee; Mr. W. A. Vollmer, Milwaukee.
5	Health for Industry by Industry	Committee on Healthful Working Conditions, National Association of Manufacturers.
6	Sick Absenteeism Recording	P. A. Neal, National Institute of Health, United States Public Health Service.
7— 8	Artificial Air for Use by Pressure Workers	Edgar End, Department of Physiology, Marquette University School of Medicine.
9	Milkers' Nodules	F. T. Becker, Duluth, Minnesota.
10	Wisconsin Rheumatism Assn.	M. C. Bornan, Milwaukee.
11—12	Diseases of the Thyroid Gland	Jackson Clinic, Madison.
13—15	The Pneumoconioses	American Medical Association.
16	Industrial Health in Medical Practice	Council on Industrial Health, American Medical Association.
17—19	Industrial Health Service in Wisconsin	Wisconsin State Board of Health, and Industrial Commission of Wis.
20	Lead Absorption and Intoxication in Everyday Life	G. H. Hansmann, and M. C. Perry, M. A., Columbia Hospital.
21—22	Tuberculosis in Industry	Wisconsin Anti-Tuberculosis Association.
23	Malaria in the Experimental Laboratory	Harry Beckman, and R. K. Ota, Marquette University School of Medicine.
24	A Health Program for Industry Based on a Modern School Hygiene Plan as Seen Through the Eyes of a Village Health Commissioner	E. B. Gute, Commissioner of Health, Whitefish Bay and Fox Point.
25	Human Convalescent Serum Center	Milwaukee Convalescent Serum Center, Columbia Hospital, M. A. Hardgrove.
26	The Diabetic Child	Milwaukee Children's Hospital, G. F. Kelly, and Nell Clausen, Dietician.
27—28	Highway Accidents and Alcohol	Committee on Safety on Public Highways.
29	Vital Statistics	Wisconsin State Board of Health
30	Maternal and Child Health	Wisconsin State Board of Health
31	The Premature Infant Feeding and Nursing Bureau, Inc.	Medical Society of Milwaukee County, James O. Kelley, Executive Secretary
32	Medical Library Service	University of Wisconsin Medical School, Gladys Ramsey, Librarian.

KEY TO TECHNICAL EXHIBITS

BOOTH 27

A. S. ALOE COMPANY
Established 1860

PHYSICIANS' AND HOSPITAL EQUIPMENT AND SUPPLIES

Los Angeles St. Louis

BOOTH 47

CASPER'S PHOTO SHOP
1331 North Twelfth Street
MILWAUKEE, WISCONSIN

A Complete Line of Photographic Supplies

BOOTH 11

BARD-PARKER COMPANY, INC.
DANBURY, CONNECTICUT

Detachable Blade Knife, Renewable Edge Scissors, Surgical Instruments

BOOTH 46

CIBA PHARMACEUTICAL PRODUCTS
Incorporated

Lafayette Park, Summit, New Jersey

RELIABLE PHARMACEUTICAL SERVICE

BOOTH 42

THE BORDEN COMPANY
350 MADISON AVENUE
NEW YORK

Biolac
Dryco
Special Dryco
Beta Lactose
Klim
Merrell-Soule Products

Borden's Irradiated Evaporated Milks

BOOTH 5

The Coca-Cola Company
ATLANTA, GEORGIA

"The Pause That Refreshes"

BOOTH 15

S. H. CAMP & COMPANY

Surgical Belts, Binders
Orthopedic Braces
Maternity and Convalescing Supports
Brassieres and Breast Supports
Supporting Combinations

JACKSON, MICHIGAN

BOOTH 40

Duke Laboratories, Inc.
375 FAIRFIELD AVENUE
STAMFORD, CONNECTICUT

Aolan, Aquaphor, Basis Soap, Collapsules, Elastoplast, Mediplast, Nivea Products

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From the G-E Office-Portable Diagnostic Unit Up to the Million Volt Equipment For Roentgen Therapy.

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For Infant and Child Feeding

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Manufacturers-Dealers-Importers

Drugs and Pharmaceutical Specialties
Physician's and Hospital Supplies

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"57 Varieties"

PITTSBURGH, PA., U.S.A.

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For Infants and Invalids
Originated by G. Mellin, 1866

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Surgeons Instruments
HOSPITAL EQUIPMENT & SUPPLIES

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CHICAGO

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ARTHUR H. NEUMANN, INC.

Surgical Instruments, Supplies and Equipment For

Physicians, Surgeons and Hospitals

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BOOTH 24

PARKE, DAVIS COMPANY

Home Offices and Laboratories

DETROIT, MICHIGAN

Pharmaceuticals and Biologicals

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PHYSICIANS AND HOSPITALS SUPPLY COMPANY

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MINNEAPOLIS, MINNESOTA

Dependable Supplies for the Physician and Hospital

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Irradiated Pet Milk

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Manufacturers of the most modern x-ray apparatus for both diagnostic and therapeutic purposes

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Supplying the Medical Profession with Vitamin Preparations for Use in Both Normal and Special Diets

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Surgical and Hospital Supplies and Equipment

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Manufacturers of a Complete Line of Fracture Equipment and Other Surgical Supplies

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Biologicals, Ampules and Glandular Products of Highest Quality and Purity

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Annual Reports of Officers and Committees to the 1940 House of Delegates

1. REPORT OF COUNCIL

Councilors: First district, *H. P. Bowen*, Watertown; second district, *C. E. Pechous*, Kenosha; third district, *W. T. Clark*, Janesville; fourth district, *B. I. Pippin*, Richland Center; fifth district, *A. H. Heidner*, West Bend; sixth district, *S. E. Gavin, chairman*, Fond du Lac; seventh district, *H. A. Jegi*, Galesville; eighth district, *G. W. Krahn*, Oconto Falls; ninth district, *H. H. Christofferson*, Colby; tenth district, *F. E. Butler*, Menomonie; eleventh district, *F. G. Johnson*, Iron River; twelfth district, *H. J. Gramling, R. E. Fitzgerald, Robert W. Blumenthal*, Milwaukee; thirteenth district, *J. W. Lambert*, Antigo; past-president, *A. E. Rector*, Appleton.

Complete minutes of all Council meetings have been published in the columns of our Wisconsin Medical Journal during the last twelve months. The Council may wish to present to the House a last-minute report on the subject of hospital care insurance.

During the year the Council and officers have had their attention directed to several sections of the constitution and by-laws and herewith respectfully recommend to the House the adoption of the amendments that follow that the constitution and by-laws may be perfected.

Amendments to the By-Laws

(1) To remove a confused wording from Section 3, Chapter VI, strike the words "from the decision of an individual councilor" in the sentence reading:

"It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken from the decision of an individual councilor."

(2) Some county medical societies desire to provide a probationary period before electing an applicant to membership. In many instances, such a period from local resolution in the county is specified at one year. Under the open panel and other like privileges of the Society, such a waiting period may constitute a rather severe penalty upon an applicant, and the Council proposes the following amendment as an optional method to be exercised if the component societies wish to do so:

Amend Section 3 of Chapter XI by striking the period and inserting a semicolon. Add the following: "or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society."

(3) At the present time the radiologic and orthopedic physicians have sections in the Society that were organized to promote both the scientific interests and discussion of the economic problems of those specializing in these fields. The Council recognizes that it is more desirable to have sections of the Society, hoping to build a general cohesive body of physicians in the State, than to have large numbers of separate and disjointed societies. To make a specific provision for the organization of these sections, however, the Council recommends the following amendment to the by-laws:

Renumber present Chapter XII to be Chapter XIII and insert a new Chapter XII, to be entitled "Scientific Sections," and to read as follows:

Section 1. The House of Delegates shall, from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

Section 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

Section 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

Section 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

Section 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

(4) In event that the House of Delegates adopts the amendment to create the chapter pertaining to scientific sections, then the Council wishes to introduce at this session for action one year later amendments to the Constitution and By-Laws to permit each section the privilege of electing a delegate to the House of Delegates, so as to give the section of certainty a voice on the floor of the House. These amendments follow:

A. Amend Chapter XII of the by-laws entitled "Scientific Sections" by adding Section 6 to read:

Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

B. Amend Article V of the Constitution entitled "House of Delegates" by inserting after the word "societies" the following:

and one delegate representing each section of the Society organized under the By-Laws.

Report on Necrology

The Council has the sad duty of reporting the deaths of the following physicians since the last anniversary meeting. Members of the Society are indicated by boldface type.

Aldridge, H. W. ____ Manitowoc
Barber, J. L. ____ Marathon
Barrett, E. J. ____ Sheboygan
Beadles, C. H. ____ Kenosha
Bergner, O. L. ____ Milwaukee
Bork, A. L. ____ Milwaukee
Brah, A. J. ____ Milwaukee
Campbell, A. P. ____ East Ellsworth
Conklin, G. H. ____ Superior
Corr, J. T. ____ Racine
Daniels, L. J. ____ Milwaukee
Dawson, C. N. ____ Black Earth
Deerhake, W. A. ____ Waupun
Erdman, C. H. ____ Stanley
Farnharm, C. R. ____ Milwaukee
Farnsworth, A. L. ____ Baraboo
Fisher, J. W. ____ Milwaukee
Flower, D. R. ____ Park Falls
Forbush, S. W. ____ Beloit
Fuerstenau, L. A. ____ Milwaukee
Guyton, E. A. ____ Eau Claire
Hackett, J. H. ____ Milwaukee
Heitman, William ____ Nashotah
Henika, G. W. ____ Madison
Henke, W. A. ____ La Crosse
Hertzman, C. O. ____ Ashland
Hilliard, H. G. ____ Minong
Hyslop, C. J. ____ Chippewa Falls
Jackson, R. H. ____ Madison
Johnson, J. C. ____ Ogdensburg
Kelly, D. M. ____ Baraboo
Knapp, E. J. ____ Rice Lake
Kutchin, Victor ____ Green Lake
Lawler, G. W. ____ Waukesha
Miller, W. S. ____ Madison
Mitchell, R. E. ____ Eau Claire
Nichols, R. M. ____ Sheboygan Falls
Nobles, B. O. ____ Milwaukee
Palmer, W. H. ____ Janesville
Peake, E. P. ____ Oshkosh
Purcell, H. E. ____ Madison
Ramsey, R. J. ____ Milwaukee
Reagles, Robert ____ Madison
Reich, W. F. ____ Milwaukee
Reinhardt, J. P. ____ Fountain City
Rhode, H. P. ____ Green Bay
Rideout, M. E. ____ Waupaca
Schulberg, P. A. ____ Durand
Scott, B. E. ____ Berlin
Sharpe, H. A. ____ Verona
Sonnenburg, C. N. ____ Sheboygan
Steffen, L. A. ____ Antigo
Storchheim, Frederick ____ Wauwatosa
Taugher, J. S. ____ Milwaukee
Tompach, Emil ____ Racine
Vernon, Sara G. ____ Madison
Washburn, W. H. ____ Milwaukee
Wilson, A. R. ____ Milwaukee
Wright, J. C. ____ Antigo

2. REPORT OF THE SECRETARY

Membership.—The active membership with dues paid for the year of 1940 was 2,333 as of July 31. This is seventy-one over the number paid at the same date a year ago. It would appear that the active membership for this year will exceed 2,500, the third successive year that there has been an increase in membership. However, the directory of the American Medical Association credits Wisconsin with 3,523 physicians. During July a member of your staff prepared a county-by-county list of all non-members under the age of 70 years who are not listed as retired. These lists have been sent to the presidents of the respective component societies for a local check as to eligibility of the men for membership in the State Society. All who are eligible for membership should participate in the work of organized medicine. For many years because of the efforts of the organization, the annual dues for the members have represented a saving in perpetuity, and in this effort all eligible should participate.

Office Effort.—The work of your Society's office during the last twelve months is reflected in the report of the committees that follow. While the staff was reduced from seven to five following the last annual meeting, the generous and continuous extra loads carried by each have made possible a large volume of work. Your secretary extends to his assistants in the office unstinted praise for a loyalty to the work in hand that alone has made many accomplishments possible.

During the year the services of the assistant secretary, Mr. Larson, again have been devoted largely to effort in the field of voluntary sickness insurance. His work is reflected in the report on that subject matter and will be noted further through the supplementary report to be made at the first session of the House of Delegates. In addition, Mr. Larson has reassumed as many of his former duties as possible, in order to relieve the load made heavy by new activities.

Of necessity the central office of the Society must act in both a correlating and executive capacity for all committee and Society effort. At times it is difficult to clear matters with dispatch, but every effort

is exerted to expedite the business of the Society. A further load will be carried in 1941 due to the legislative session, which makes it doubtful that further new activities can be assumed without a staff increase.

Public Presentations.—Since the House of Delegates met last September your secretary has addressed the following lay bodies:

Sept. 28—County and city superintendents of schools of Wisconsin, Madison
Oct. 31—Saturday Club, Watertown
Nov. 6—New Century Club, Detroit
Nov. 10—Superior State Teachers College, Superior
Dec. 11—Chamber of Commerce, Topeka, Kansas
Dec. 18—Platteville Schoolmen's Club, Platteville
Dec. 19—Fox River Valley Insurance Association
Jan. 13—Century Club, Oshkosh
Jan. 16—Woman's Club, Mayville
Mar. 5—Twentieth Century Woman's Club, La Crosse
Mar. 26—Knights of Columbus, Madison
Apr. 5—State Nurses' Association, Milwaukee
Apr. 9—Woman's Club, Rhinelander
Apr. 18—Business and Industrial Department, Y.W.C.A., Madison
Apr. 23—Brown County Council of Social Agencies, Green Bay
May 14—Rotary Club, Fort Atkinson

Societies Visited.—In addition to committee attendances and numerous conferences with other bodies interested in public health work, your secretary has addressed meetings of officers in eleven of the thirteen councilor districts.

He has further addressed meetings of the following medical societies:

Nov. 21—Medical Society of County of Westchester, White Plains, New York
Dec. 5—Scott County Medical Society, Davenport, Iowa
Dec. 6—Waukesha County Medical Society
Dec. 11—Topeka Medical Society, Topeka, Kansas
Dec. 14—Dodge County Medical Society
May 28—Columbia–Marquette–Adams County Medical Society, Portage
June 8—Green County Medical Society

Additional Report.—There are several matters now pending upon which your secretary will make a final report when the House convenes.

Appreciation.—Your secretary expresses his deep appreciation to the officers, committee members, and members of the Society whose generous assistance and kindly suggestions, throughout the year, alone make possible the accomplishments of the year.

3. REPORTS OF STANDING COMMITTEES

THE CANCER COMMITTEE

Marcos Fernan–Nunez, chairman, R. C. Thompson, R. L. Alvarez, H. L. Schwartz, H. H. Morton, C. A. Richards, E. E. Evenson, J. W. McGill, E. F. Schneiders, R. W. Hammond, Erich Wisiol, Charles Fidler, G. E. Eck, D. J. Twohig

The activities of the Committee on Cancer during the last year have been devoted largely to public education in cancer prevention. This has been chiefly in collaboration with the Wisconsin unit of the Women's Field Army of the American Society for the Control of Cancer. The Wisconsin campaign of cancer control has attracted national attention and is considered generally to be one of the most effective programs being carried out in the various states.

During the year the chairman of the Committee on Cancer gave talks on cancer control before the State Medical Society of Wisconsin, Medical Association of Georgia, Wisconsin Pharmaceutical Society, Catholic Hospital Association of America, Wisconsin Safety Conference, Marquette University, five county medical societies, numerous clubs, churches, schools and over various radio stations. He also prepared radio scripts for national use by the American Society for the Control of Cancer, and an article on early diagnosis of cancer in general practice for the WISCONSIN MEDICAL JOURNAL.

Approximately 300 addresses before lay audiences over the state were given by members of the Committee on Cancer and physicians representing the local medical societies, with a total attendance of over 60,000 persons.

During the months of April and May the Milwaukee street cars and buses carried inside and outside posters emphasizing that early cancer is curable and advising that inquiring persons consult their family doctors.

Eighty-two radio broadcasts were given over the stations at Wausau, La Crosse, Eau Claire, Racine, Superior, Madison, Portage, Beaver Dam, Manitowoc, Rice Lake, Stevens Point, Milwaukee, Green Bay, Fond du Lac, Sheboygan, University of Wisconsin and Marquette University.

Radio broadcasts constitute the most extensive and effective means of getting the cancer control message to the public. They reach a greater number of people than all the other means combined and contact thousands who would not be reached by the other publicity methods employed. The radio campaign could easily be doubled in effectiveness if the name of the speaker could always be announced since the authority of his name would be given to the talk.

Exhibits composed of cancer models, chromographs, posters, lantern pictures and free literature were presented at the meeting of the State Medical

Society of Wisconsin, Medical Association of Georgia, American Society for the Control of Cancer, Wisconsin State Dental Society, Wisconsin State Nurses Association, General Federation of Women's Clubs, American Legion; the county fairs of Marinette, Sheboygan, Price, Wood, Shawano, Dodge, Vernon and Jackson counties; University of Wisconsin, Marquette University and several public schools. Exhibits were also shown at various places in Westfield, St. Croix Falls, Beaver Dam, Superior, Junction City, Merrill, Lannon, Blair, Eagle River, Sauk City, North Freedom, Reedsburg, Sheldon, Racine, Gordon, Lomira, Oakfield, Madison, Milwaukee, Horicon, Oconomowoc, Sheboygan and Wauwatosa.

The Wisconsin exhibit set-up has attracted national attention and one outfit has been loaned to the Georgia Cancer Commission for a tour of that state, following which it will go to South Carolina and Florida. The American Society for the Control of Cancer has requested its use for national conventions of lay organizations.

Over 5,000 inches of space on cancer control were carried by Wisconsin newspapers during the past year but especially during the April educational and enlistment campaign. This is a marked increase over previous years. Formerly it was difficult to get the public press or the radio stations to use material on cancer as the subject was thought to be repulsive to the average layman. The work of the Women's Field Army is rapidly bringing a change in viewpoint on cancer among all classes of the public and making it possible to secure donations of newspaper space and radio time and other avenues of publicity which would be practically impossible for organized medicine to command because of the great expense.

From its memorial fund the Women's Field Army has offered to pay the expense of providing a speaker on cancer for the annual spring clinics of the State Medical Society. This fund was started by gifts of $100 each from Governor Julius P. Heil, ex-governor Walter J. Kohler, Mr. F. J. Sensenbrenner of Neenah and Mrs. E. J. Kearney of Milwaukee. The donors have approved its use for graduate conferences on cancer for physicians in the belief that in this manner it would be of the greatest possible service to the public.

A very successful round-table conference on traumatic cancer was held under the auspices of the Committee on Cancer during the 1939 annual meeting of the State Medical Society in Milwaukee. It was the consensus of opinion at this assembly that a single blow or trauma, contrary to the general opinion prevalent among the public, rarely ever causes cancer but that chronic irritation is the usual cause.

Approximately 100,000 pieces of literature on cancer for lay readers were distributed during the year. Our experience indicates that each pamphlet or dodger is read by several persons and comes to the attention of practically all the members of a family into which it is taken. In some communities the chain letter system is used whereby each piece of literature is passed on to ten or more persons by the one originally receiving it.

During the fiscal year the campaign for funds for support of the work of the Women's Field Army raised $8,441.48, as shown by the accompanying table:

County:	
Adams	----
Ashland	$ 57.30
Barron	115.00
Bayfield	28.00
Brown	----
Buffalo	38.00
Burnett	28.35
Calumet	36.43
Chippewa	37.06
Clark	54.40
Columbia	65.40
Crawford	----
Dane	135.10
*Dodge	613.90
*Door	396.37
Douglas	118.05
Dunn	2.00
Eau Claire	----
Florence	----
Fond du Lac	193.62
Forest	50.00
Grant	250.97
Green	15.00
Green Lake	31.10
Iowa	23.00
Iron	43.09
Jackson	51.09
Jefferson	263.92
Juneau	5.00
Kenosha	----
Kewaunee	25.00
La Crosse	95.29
Lafayette	9.01
Langlade	5.97
Lincoln	116.11
Manitowoc	188.00
Marathon	3.00
Marinette	308.80
Marquette	33.11
Milwaukee	914.06
Monroe	----
Oconto	----
Oneida	44.01
Outagamie	4.00
*Ozaukee	519.05
Pepin	----
Pierce	----
Polk	154.11
Portage	7.00
Price	170.28
Racine	4.00
Richland	----
Rock	49.00
Rusk	60.90
St. Croix	9.00
*Sauk	444.88
Sawyer	29.95
Shawano	28.45
*Sheboygan	813.75
Taylor	42.44
Trempealeau	171.40
Vernon	44.25
*Vilas	81.41
Walworth	27.78
Washburn	69.75
Washington	102.35
*Waukesha	778.53
Waupaca	6.00
Waushara	1.00
Winnebago	12.00
Wood	176.91
Wis. Fed. of Women's Clubs	38.78
Memorial Fund	200.00
Total	$8,441.48

* Counties over their quota of $1.00 per hundred population.

The counties showing few or no contributions have not been completely organized. Much of the funds of the Women's Field Army is spent in regions of the state which cannot well support educational

campaigns against cancer, while 30 per cent of all funds collected is sent to the central office of the American Society for the Control of Cancer for use in carrying cancer prevention propaganda to underprivileged areas of the Nation. This is the custom of all the state organizations of the Women's Field Army. The cancer campaign in Wisconsin is seriously handicapped by inadequate funds and its full effectiveness will hardly be felt in this state until at least $25,000 yearly are available.

The State Board of Health supplied the Women's Field Army with literature on cancer to the value of $1,000 for public distribution during the last year.

The records indicate that approximately 5,000 persons last year died of cancer in Wisconsin. Cancer statistics are far from adequate in the state due largely to the failure of physicians to report their cases. The Committee on Cancer has been greatly concerned over this situation and strongly urges every doctor to cooperate carefully in reporting cancer cases on the special forms provided by the State Board of Health. It is estimated that for every death from cancer there are three living patients with cancer, which means that there are around 15,000 persons suffering with cancer in Wisconsin. The death rate from cancer should be reduced one third or even one half by widespread use of known methods of prevention and treatment.

ADVISORY COMMITTEE ON CARE OF CRIPPLED CHILDREN

H. K. Tenney, chairman, J. B. MacLaren, H. L. Greene, J. O. Dieterle, H. H. Christensen, C. M. Kurtz

The main activity of the Advisory Committee on Care of Crippled Children has been concerned with the reorganization of the field clinics. As there evidently had been growing dissatisfaction with the results of the clinics on the part of all concerned, it was decided to resurvey the whole problem with the hope that a more efficient plan might be evolved. As a result of several conferences some changes were agreed upon which may be summarized as follows:

Supervision of children in the orthopedic schools is not to be a part of the work of the field clinics. Clinics are to be held in cities other than those in which there is an orthopedic school. Clinics are to be limited to examination of new patients who have been referred by their family physician after examination by him to determine their physical, nutritional, and mental status (in this connection it is recognized that considerable leeway must be allowed in appraising the mental status of physically handicapped children). The number of patients admitted to the clinic is to be limited to the number the orthopedists feel they can handle efficiently. The orthopedist is not expected to make final recommendations on those patients for whom he deems hospitalization advisable as it is obvious that such recommendation can be made more accurately after complete studies in the hospital.

Supervision of children in the orthopedic schools is to be effected by having an orthopedist visit the same school once or twice a year. Thus he can outline to the physiotherapist what it is hoped can be accomplished for each patient during the year and can recheck the results later.

Obviously there are many details to be worked out, but these are the broad principles on which we are working.

COMMITTEE ON GOITER

A. S. Jackson, chairman, J. M. Johnson, J. H. Armstrong, E. L. Sevringhaus (ex officio), C. N. Neupert (ex officio)

During the last year studies on the amount of iodine found in the urine of children taking iodized salt have been undertaken for the Committee on Goiter by Mr. J. H. Barbour under the direction of Dr. E. L. Sevringhaus. A recent report shows that the series of analyses, from infancy to adolescence, is now practically complete. The committee expects to review the completed report of these investigators within the next few months and then advise the Society as to its recommendations regarding the use of iodized salt in Wisconsin. If it is decided to favor the use of iodized salt for general goiter prophylaxis, legislative action may become necessary in order to make its use effective. For this reason, the committee felt it must be very certain of the facts and consequently this useful method of studying the value of iodized salt in children was undertaken during the past year. At the present time, Dr. Sevringhaus states the results are consistently showing that with the use of iodized salt the iodine excretion in the urine is considerably higher than has been found in non-goiter regions. While a fund of $150 was made available by the Council for this study, the cost for this work to date is only $35.

In February a letter was sent by the committee to the presidents of all component county medical societies regarding goiter prevention in Wisconsin. These officers were advised of all facts on this subject so far ascertained by the committee, and they were requested to read this letter before a meeting of their societies. The purpose of the letter was threefold; namely, to keep the subject alive, to present any new data that the committee had gathered, and to ascertain the present status of prophylaxis in the various counties. Attention was called to the fact that while goiter is apparently decreasing throughout the goiter belt, hypothyroidism and cretinism, the end results of goiter, are on the increase, particularly in Wisconsin.

A list of the iodine tablets approved by the Council on Pharmacy and Chemistry of the American Medical Association was made available to the members, together with pertinent facts regarding prophylaxis. A questionnaire was addressed to the

chairmen of committees on goiter prevention in the various county medical societies. This letter was prepared with the kind assistance of Dr. R. G. Arveson, president of the State Medical Society. Again it was emphasized that the initiative and direction of the prevention campaign must come from the medical profession.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

E. J. Carey, chairman, F. B. Sazama, J. A. Riegel

The Committee on Health and Public Instruction has had its activities curtailed during the last year, to a marked degree, by actions taken by the House of Delegates in the 1939 session. The committee formerly supervised the preparation and distribution of health programs presented over several radio stations throughout the state. In accordance with the wishes of the House, these programs were discontinued shortly after the close of the 1939 session of the House.

During past years, another effort of this committee has been the preparation and distribution of statement inserts to members of the Society, for inclusion with physicians' statements to their patients. Intensive efforts were made by the committee to induce the members to use them either as enclosures with their statements, or as waiting room literature. In spite of bulletins, advertisements in the Wisconsin Medical Journal, and other media of publicity, this means of public education was not used extensively enough by the members to warrant the time, effort, and expense involved in preparation of the inserts. Therefore, this public health activity also was discontinued.

The reasonably satisfactory results of the committee's efforts to establish a speakers' bureau of state-wide application have been witnessed by the committee. It is to be recalled that this committee in 1939 called together representatives from each county medical society to attend a full day's session to consider the subject of presenting health information to the public, together with the attitudes and concepts of medicine. This meeting resulted in the appearance of a number of physicians before lay audiences, but your committee feels this effort should be markedly extended.

Newspaper releases to every weekly and daily newspaper in the state have been continued. These releases have met with reasonably satisfactory acceptance by newspaper editors throughout the state. This effort would be possible of expansion if more time of the executive personnel could be devoted to it without jeopardizing other activities which might be considered of greater import.

The committee has had under consideration during the past year, the possibility of conducting a 1941 centennial edition of the public health exhibits presented in the Milwaukee Auditorium in 1937. The thought of the committee has been to make it possible to present such health exhibits in several communities in the state throughout the year. This public educational effort should be coordinated with the committee in charge of the centennial celebration.

There are but two means of advising the public of the public health aims of medicine. They are either visual or auditory.

In the auditory classification, the only means open to the profession are:

1. Radio
2. Public lectures

The visual means are:

1. Newspapers
2. Literature by mail, such as statement inserts
3. Motion pictures
4. Film strip or lantern slide presentations

At the suggestion of the committee the initial work in the preparation of a film strip was begun. This is to set forth in pictorial form the achievements of medicine in the past and the inherent dangers found in compulsory sickness insurance. This type of public educational effort must be exceedingly well prepared and presented, and will entail some expense in artistry and production. The committee feels that this work should be continued during the ensuing year and if possible accentuated in order that it might be completed during the present calendar year.

Your committee feels that we are in a critical period of public education, and that financial means should be found to make possible an effective public educational program.

COMMITTEE ON INDUSTRIAL HEALTH

S. J. Seeger, chairman, E. O. Gertenbach, T. J. O'Leary

On October 9, 1939 the Committee on Industrial Health met with the Wisconsin Industrial Commission for a discussion of the program of physical examinations in industry.

The committee met again on November 16, 1939 and it was agreed that:

1. It recommend to the Council of the State Medical Society that the Council, in the name of the Society, approve the principles of physical examinations for employes in industry.
2. The attention of the Council be officially directed to the program of the Wisconsin Industrial Commission; to a communication from Mr. Harry A. Nelson, director of the Workmen's Compensation Division, to the secretary of the State Medical Society, requesting suggestions for the appointment of an advisory committee; and to the recommendation of the Committee on Industrial Health that the State Medical Society, in such manner as is acceptable to the Council,

provide Mr. Nelson with the suggestions he requested.

3. The secretary see Dr. C. M. Peterson, secretary of the Council on Industrial Health of the American Medical Association, first to ascertain his views on the Wisconsin program, and, secondly, (with the thought that any close supervision of the development of the Wisconsin program was too much for a voluntary committee) to ascertain whether the Council on Industrial Health of the American Medical Association could, and would, consider a special field project in Wisconsin during the period of the development of this program.
4. A substantial exhibit in the field of industrial health be arranged as a feature of the scientific exhibit at the 1940 annual meeting, and the cooperation of the Council on Scientific Work be sought in order to secure the placement of papers on this general subject, to cover at least a half day of the general session.

The chairman of the committee presented the recommendations to the Council at the January session and the Council approved them.

On December 21, 1939 the committee held a meeting with Dr. Paul Brehm of the Industrial Hygiene Unit of the State Board of Health, and Dr. C. M. Peterson, secretary of the Council on Industrial Health of the American Medical Association, for a general discussion of the problems presented by the physical examination program of the Industrial Commission. The Council authorized the committee to submit a list of six names to the Industrial Commission, adding thereto the names of the president of the Society, chairman of the Council and the secretary of the Society. To date the committee has not been informed of any action on the part of the Industrial Commission in this matter. In presenting the program of the Industrial Commission to the Council, the committee stressed the point that in order properly to organize practicing physicians and the facilities of the medical profession for physical examination programs on a broad scale, the services of a field worker from the secretary's office would be necessary. The amount of time and effort entailed in coordinating properly the various agencies so as to present a set-up for physical examinations which would insure the success of the program is beyond the resources of a practicing physician working on a voluntary basis.

The committee has arranged with the Council on Scientific Work to make industrial medicine an important feature of the annual meeting of the Society in September. At least a half day of the scientific sessions will be devoted to papers on industrial health problems. In addition, nineteen booths of the scientific exhibits have been reserved for exhibits dealing with problems in the field of industrial health. The following is a list of these exhibits:

1. *Cooperative Medical and Engineering Effort in Industrial Health*—Dr. E. G. Meiter, et al.
2. *Health for Industry by Industry*—Committee on Healthful Working Conditions, National Association of Manufacturers.
3. *Sick Absenteeism Recording*—National Institute of Health, United States Public Health Service.
4. *Artificial Air for Use by Pressure Workers*—Dr. Edgar End, department of physiology, Marquette University Medical School.
5. *Milkers' Nodules*—Dr. F. T. Becker.
6. *The Pneumoconioses*—American Medical Association.
7. *Industrial Health in Medical Practice*—Council on Industrial Health, American Medical Association.
8. *Industrial Health Service in Wisconsin*—Dr. Paul Brehm of the State Board of Health, and the Wisconsin Industrial Commission.
9. *Lead Absorption and Intoxication in Everyday Life*—Dr. G. H. Hansmann and M. C. Perry, M.A.—Columbia Hospital.
10. *Tuberculosis in Industry*—Wisconsin Anti-Tuberculosis Association.

In addition to the above activities in the broad field of industrial health during the past year the Society has:

1. Held two meetings with representatives of insurance carriers (both old line and mutual) for the purpose of furthering the open panel program, ironing out difficulties thereunder so as to provide the injured workman under the workmen's compensation act with free choice of physician from all members of the Society capable and willing to undertake such care.
2. Recompiled the panel referred to in the preceding paragraph, which is an effort that requires substantially two months of time of one highly trained person, a voluminous amount of correspondence to answer questions that are raised in connection therewith, and a total expenditure in the neighborhood of $500 for postage and printing.
3. Held several conferences with Mr. Harry A. Nelson and members of the Industrial Commission to discuss the proposed pre-employment and employment physical examination program. The proposed examination blank has been studied by legal counsel and a modification offered to the Commission to make certain that the physician reporting to the employer does not violate the confidential relationship of physician and patient. This modification of the blank is now awaiting approval of the Commission.
4. Held a conference with representatives of the State Board of Health to assure support of the State Medical Society in a properly defined program to acquaint nurses employed in

industry with their opportunities and limitations. In connection with this same subject the Society re-issued in 1939, its bulletin of standing orders for nurses in industry after extensive revision. Over 500 copies of this bulletin were distributed to nurses in industry throughout Wisconsin, thus almost eliminating complaints from members as to unauthorized and unsupervised practices detrimental to patient health.

5. Compiled a booklet on the evaluation of disability under the Workmen's Compensation Act. This was sent to all members at a cost of about $300.

The following suggestions are submitted for the reorganization of the Committee on Industrial Health. These are based, in part, on suggestions which were made at the second annual congress of the Council on Industrial Health of the American Medical Association.

The activities of the Committee on Open Panels dovetail with those of the Committee on Industrial Health, and for that reason it is suggested that consideration be given to the desirability of a closer correlation of the work of these two committees. It is possible that this might be effected by the organization of a Grievance Committee as a subcommittee of the Committee on Industrial Health.

On the basis of discussion at the second annual congress by chairmen of other state committees, and, also, on the basis of experience, it is suggested that it is desirable to have the following groups represented on the Committee on Industrial Health:

1. The private practitioner.
2. The full-time industrial physician.
3. A medical representative (if such exists) from each of the following:
   a. Industrial Hygiene Unit of the State Board of Health.
   b. An industrial insurance company.
   c. The State Department of Labor or the Industrial Commission.
   d. The medical faculties of the state.

It is further suggested that continuity of program and services be provided by staggered appointments.

COMMITTEE ON MATERNAL AND CHILD WELFARE

A. B. Schwartz, chairman, J. W. Harris, J. G. Taylor, Amy L. Hunter, C. M. Echols, A. E. McMahon

The Committee on Maternal and Child Welfare acts primarily as an advisory group to the Bureau of Maternal and Child Health of the State Board of Health. In previous years this committee has assisted in the development, preparation, and presentation of graduate courses in the field of obstetrics and gynecology. This year the committee's work has consisted of a further consideration of means of graduate professional education. The State Board of Health consulted this committee after the board had secured a social security appropriation to provide for the employment of a physician highly trained in the field of obstetrics and gynecology. After this physician had begun his employment with the State Board of Health, the Bureau of Maternal and Child Health sought suggestions from the advisory committee for the use of such personnel in the field of graduate education.

The committee considered several methods of graduate education wherein this physician might most effectively apply his talents, and after careful consideration it recommended that for an experimental period of three months he act as a consultant to the physicians in a specified territory including Oconto, Langlade, Forest, Shawano, Florence, and Marinette counties. The committee made this recommendation on the following conditions:

1. That he act purely as a consultant.
2. That he receive no remuneration either in kind or cash from physicians or patients.
3. That he be available to all physicians in that area.
4. That such a consultation service is welcomed by the local county medical society.
5. That at least three practicing physicians give assurance of supervision and guidance.

The committee feels that such an effort should be tried on an extremely limited experimental basis as it is apprehensive concerning possible widespread and improper application.

COMMITTEE ON MENTAL HYGIENE AND INSTITUTIONAL CARE

A. W. Bryan, chairman, G. E. Seaman, H. H. Christofferson

Members of the committee have met frequently as a group or in pairs throughout the year to discuss matters pertaining to the function of the committee.

1. **Reorganization.**—Under chapter 435 of the laws of Wisconsin, 1939, certain departments of the state government were consolidated to "promote greater efficiency and economy in administration, creating a state department of public welfare. . . ." Under this provision, with the consent of the Senate, Governor Julius P. Heil appointed R. J. Everhardt of Whitewater, Mrs. Erma Stoddart of Beaver Dam, Mrs. Yvonne Town of Waukesha, Herman Kloppman of Crivitz, Lloyd V. Ballard of Beloit, Charles H. Liehe of Chippewa Falls, and Frank W. Wabiszewski of Milwaukee as the State Board of Public Welfare. This Board named Frank Klode, the last president of the Board of Control, as director of the new department. Mr. Klode, with the approval of the State Board of Public Welfare, appointed the following division directors: A. W. Bayley (acting director) administration and research; Dr. G. E. Seaman (acting director) mental hygiene; George M.

Kieth, public assistance; Elizabeth Yerxa, child welfare; Dr. Morris G. Caldwell, corrections; and E. F. Costigan, adult blind service. A. W. Bayley is also executive secretary of the department.

2. Progress at the State Level.—The director of mental hygiene on January 9, 1940 submitted, for the betterment of the institutions under the division of mental hygiene, the following program, calling for:

a. Special tuberculosis facilities at the Northern and the Southern Colonies with necessary amplification of hospital facilities.

b. Epileptic colonies.

c. An institution for inebriates.

d. Necessary additions to the Central State Hospital for Insane to include accommodations for women.

e. Necessary medical and hospital facilities at the new industrial school for girls at Oregon.

f. Hospital facilities including a special department for tuberculosis at the Waupun State Prison.

g. Rearrangement and amplification of the hospital facilities and main building at the Winnebago and Mendota State Hospitals.

Practically all of these projects are now assured except those which require an act of the legislature to create new institutions.

Alcoholics: The problem of handling the inebriate, who is *persona non grata* in all hospitals both public and private, except in those which are especially prepared for his care, has been receiving consideration. Among the objections to this type of patient are his failure to cooperate and his tendency to frequent remissions. Some such patients have been known to appear before magistrates at least a hundred times. It is to be hoped that a special institution, perhaps of colony type, may soon be available for the prolonged and specialized care of inebriates. Experience indicates that readmittances are few among inebriates who remain under care for as long as six months and frequent among those who remain under observation only a few days. It is true that the county judge may commit such a person for thirty days of observation plus an additional ten days either as an inebriate or as an insane person if he exhibits psychoses. However, this committee feels, along with hospital administrators, that any patient admitted to a state institution, whether or not he comes as a voluntary patient, should be required to remain thirty to ninety days unless, in the judgment of the staff, he can be discharged earlier. This period should probably be regarded as probationary to permanent institutional care.

Under the present law (49.07) an "inebriate" is defined as "a person given to excessive use of intoxicating drink, who has lost the power or will, by frequent indulgence, to control his appetite for it."

Section 51.26 (5) provides that inebriates previously committed to county institutions may be transferred to the state institution at Mendota or Winnebago if the county judge feels it for the best interests of society or for the patient.

Section 51.26 (6), states that three citizens, one of them the wife or nearest relative if available in the county, otherwise a poor commissioner, may petition any judge of a court of record for commitment. If the court finds the person an inebriate and commitment necessary, the judge may commit him to a county asylum (or in Milwaukee county to the Milwaukee County Hospital for Mental Diseases) or to a state hospital (Mendota or Winnebago) as follows:

a. for such period of time as the court may deem necessary for curing the malady, or

b. for such period of time as, in the judgment of the superintendent and attending physicians, it may be necessary for him to recover and be able to care for himself.

Section 348.351 states that the common drunkard is a vagrant and may be sentenced to the county jail for a period up to ninety days, or to solitary confinement for not less than three or more than ten days. Under 359.14, known as the repeater statute, he may be sentenced to the county jail for not more than one year or to the state prison for not more than three years or less than one.

Mental Hygiene: The Psychiatric Field Service which has recently been reorganized on a sound economic basis consists of ten psychiatrists, psychologists and physicians, and two stenographers. The traveling clinic has been abolished and in its place each penal and correctional institution has been established as an examination center. The primary function of this service is to give physical, psychological and psychiatric examinations to the following: all inmates received at these institutions, all probationers and applicants for parole or pardon consideration, individuals developing mental disturbances during incarceration, and "problem cases" referred by administrators. It is also planned to have this type of service made available throughout the state to problem cases in which the public has an interest, probably at strategically located mental hygiene clinics so situated as to take advantage of facilities and personnel of existing state and county institutions.

Tuberculous Insane: Numerous tuberculous surveys of all the state and many of the county institutions have been made in recent years. These surveys are continuous and all patients admitted to state institutions are routinely examined by the hospital staff in consultation with tuberculosis experts, designated by the State Health Department and employed by the Department of Public Welfare. In the state and county institutions, special facilities are provided and repeated surveys show the incidence of this complication to be greatly reduced among mental patients in state institutions. It must be remembered that many of these patients are greatly reduced in their physical health; they have a lowered general resistance and are readily susceptible to all types of infectious processes.

3. **Progress at the County Level.**—At the county level much satisfaction is to be had in realizing that many of the old county asylums which were so frequently mainly domiciliary institutions are now vying with each other in the improvement of their medical and nursing care and facilities. This is in accordance with the recommendations of this committee in its 1936 report to the House of Delegates, as well as those of other investigators since that date. Many institutions now have trained nurses who are qualified as laboratory technicians; they have more adequate records than formerly and some have hydrotherapy or other equipment "on order." More are doing Wassermann tests, giving insulin shock therapy, supplying adequate surgical services and the like. There is need for x-ray equipment in most of these institutions. Marathon, Racine and Walworth counties have provided adequately equipped county hospitals in connection with their mental institutions. Brown, Sheboygan and Outagamie counties have recently occupied new and up-to-date plants.

There is need for certain of the county asylums or hospitals—especially those about the margins of the state—to set up equipment as temporary receiving stations in order to eliminate the long-distance transfer of acutely ill, disturbed, alcoholic, or senile patients to the state hospitals, and to prevent the incarceration—as has occurred—of such people in jails.

This committee feels that the initial examination as performed on order of the judges should be required to be more complete especially in its physical aspects as many cases are on record in which persons with pneumonia, meningitis or postpartum fever with psychosis are transported to mental hospitals instead of being cared for in general hospitals until the acute phases of the illness subside; seemingly unnecessary deaths have resulted under these circumstances.

Many patients with diabetes or chronic heart disease, syphilitic patients who have had maximal amounts of specific treatment, and similar individuals, constitute a static load in the state institutions designed mainly for acute cases. It is felt that certain county hospitals with adequate medical, hospital and nursing facilities should care for these people, perhaps at a higher rate than that charged in the case of the domiciliary type of patient.

More patients in the senile group—perhaps four or five per week—are being admitted directly to the county hospitals. This is as it should be where the prognosis is extremely guarded and longer journeys offer more harm than good. The detailed investigation by one of us at the request of the governor in 1937 is a case in point. The county judge has full authority to arrange such admittances in counties which have their own institutions, but must send copies of the procedure to the Public Welfare Department; in counties without institutions, arrangements must be made through the Public Welfare Department.

The county institutions are now approaching their capacity so closely that necessary elasticity in vacancies is only half what it should be for efficient administration. With a monthly increase of about twenty patients in county institutions, it is clear that additional bed capacity will continue to be a problem. In view of trends described above, it appears that the construction of one or more new county institutions, probably in the northern part of the state may be a more economical answer to this problem than the construction of a third state institution in the northwestern part of the state, as has been suggested by certain investigators.

It is clearly evident that Wisconsin is making progress with these problems. As a result of long experience, Wisconsin, more than ever, is committed to the county system which has had the endorsement of many of the world's leading psychiatrists and administrators.

4. **Changes in the Commitment Statutes.**—The 1939 legislature enacted certain laws which were of interest to this committee.

Chapter 458 revised the law relative to commitments and procedure in insanity, viz:

a. The judge may dismiss the application if he is satisfied from examination of the application and petitioners or from a personal examination of the alleged insane person that the application is without merit, or he may

b. Detain the person and appoint two physicians to examine the patient and report their findings and if the patient is reported not insane the application is dismissed, or

c. If he concludes that the patient is insane, he shall notify the alleged insane person that application has been made for inquiry into his mental condition and that a hearing will be held. If it appears from the physicians' report or from personal examination by the judge that the patient has not sufficient mentality to comprehend the notice for hearing, such notice need not be given and the hearing may be held as soon as practicable. Also, if no jury trial is requested and the judge is satisfied from all the evidence that the patient is insane he may order his commitment to a hospital or asylum stating in his order whether or not personal notice has been given to the person adjudged insane and, if no notice was given, the reason therefor. The appointment of a guardian ad litem as well as the qualifications of the examining physician are also discussed in this act.

Chapter 331 provides that veterans, if adjudged insane in accordance with the above procedure, may be committed to a United States veterans' facility upon receipt of a certificate of eligibility from the Veterans' Administration.

Chapter 524 revises the law relating to dependent, delinquent or minor children by clarifying numerous provisions, raising the age of dependent children to

eighteen and strengthening the law relating to adoptions.

Aside from these changes in the laws which were worked out largely by a committee of the County Judges Association in consultation with physicians, psychiatrists and others, a legislative committee under the responsibility of the Wisconsin Society for Mental Hygiene, Dr. Gilbert J. Rich, Milwaukee, chairman, is undertaking a review of the statutes relating to the care of the mentally ill. It is hoped by that group that it may suggest provisions designed to suggest to the legislature methods more in harmony with modern standards and practices. The chairman and the committee recognize that to make such suggestions intense study of the problem is necessary and that there must be cooperation and consultation between them and members of the State Bar Association and state officials in order to evolve the best and most acceptable procedure.

5. **General Hospitals.**—The need for well located general hospitals to equip a ward or even a few beds for the care—if only temporary—of mental and alcoholic patients must be stressed. This is important both for the protection of the patient, other patients, and the hospital itself. One of us recently visited the St. Luke's and Michael Reese Hospitals in Chicago and was impressed by such progress made there. We suggest that interested doctors or hospital superintendents also visit these places.

Summary and Conclusions.—1. Much progress is being made in this field and a subsequent report may be necessary to the House of Delegates to appraise it of specific changes at the state level.

2. The county asylums are becoming more adequate medically but even more progress in accordance with criteria mentioned in previous reports is indicated.

3. The commitment laws have been revised but further recommendations in the field are being studied.

4. With 14,099 patients in state and county hospitals and 2,459 on parole as of June 1, 1940, the care of these patients is an acute problem. In previous reports of this committee it has been recommended that an increase in the medical staffs would relieve the pressure and need for construction of additional beds. This opinion was also held by the Subcommittee on Health and Disability of the Governor's Committee on Public Welfare.

COMMITTEE ON PUBLIC POLICY

S. E. Gavin, chairman, J. C. Sargent, C. A. Dawson; president, president-elect, secretary ex officio

The Committee on Public Policy has studied in great detail more than 500 suggestions compiled from the membership as a whole and wishes to ask the House of Delegates' approval of the following program:

Within the last decade our state and nation have been confronted with a series of crises, first economic and then assuming a deeper hue of international politics and power. There are few of us who ten years ago would have prophesied that within our lifetime there would be those developments now characterized as the decline of a great empire and the ascendency of another. There are few of us who, having witnessed a great disarmament conference in the early twenties, would have believed that our country would begin re-arming within a period of less than twenty years at a rate and cost never before experienced in our history. Nor in the history of this nation has there been a period when the strength of minorities apparently was judged by the power of their outcries, nor indeed a period when there were more minorities, and the majority perhaps better described as a plurality.

Panaceas for real ills and for imaginary ills have become rampant, and there appears to be a plethora of those eager to bear the robes of the crusader. It is a period when the radio and the press are utilized in a many-sided effort to promote the views of those who feel that any change is synonymous with progress and that, above all, haste is important.

Those who decry paternalism in private industry oft hail it from the government. And there are those who feel that only through a paternalistic government can the present program, involving admitted economic implications, be carried out to a successful conclusion.

In this battle of progress, each institution of the country must stand on its own merits, for democracy, the one collective of them all, is now said to be meeting its supreme test. In the judgment of your committee, organized medicine must abandon its defensive position and assert before the people of this country its right and need to determine its own destiny, that it may continue to serve in the future, as it has so well in the past, the public health of this country.

"The medical profession is too great and vitally important to the welfare of society to be kept on the defensive," significantly declared Dr. C. A. Harper, state health officer of Wisconsin, in commending the president of our Society this spring for his forward-looking approach to the health problems of the State. If medicine is not to continue in just its purely defensive aspects, then there must be significant change materially to broaden the scope of our effort.

Appreciative that no group can consider itself prophetic, your Committee on Public Policy attempts no conclusion as to what the future holds for the public health and organized medicine. Yet if the people are ultimately to judge its place in the American scheme of things, then medicine must become increasingly vocal in its beliefs and convictions.

COUNCIL ON SCIENTIFIC WORK

E. J. Carey, chairman, G. W. Krahn, C. J. Smiles, E. R. Schmidt, W. S. Middleton (ex officio)

The Council on Scientific Work met on repeated occasions during the last year to intensify its activities in medical education. In addition to the usual problems coming before this body, the question of the development of a special scientific program for the centennial meeting of the Society was discussed with the special committee on the centennial celebration. No final determination was reached on this question.

The customary work of the Council on Scientific Work has been divided into three major fields. One of these is the presentation at the annual meeting of a well considered scientific program incorporating both lectures and outstanding scientific exhibits. As has been the custom in the past, an effort was made by the Council on Scientific Work to develop continuity in the scientific program from one year to the next, and to select one phase of medicine for emphasis during that period. This year both the scientific program and the scientific exhibits will emphasize the question of industrial health.

An interim activity of the Council on Scientific Work is the presentation of the spring clinics held in three communities in the state. The concept in the development and presentation of these spring graduate clinics has not been primarily one of obtaining a large attendance; the effort, on the contrary, has been directed to reach communities in which throughout the year the physicians do not have an opportunity to avail themselves of the new advances in scientific medicine. This approach to the problem of graduate education arose from the fact that during the last several years the annual meeting of the Society has been held in Milwaukee, this being the only city in Wisconsin with facilities to take care of the growing demands for commercial and scientific exhibits, as well as meeting halls. The council has made an intentional effort to reach out into communities that are not heavily "physician-populated," knowing in advance that the attendance at such clinics might be limited. These clinics have been well received in the communities in which they have been presented. In your council's experience, it has recognized some of the shortcomings of these clinics, and it is in a position to rectify them in the future. It will probably not be possible, at least in the immediate future, to make them self-financing. However, it is felt that this educational effort is one of the most important activities of the Society and that it should be continued even in the face of a reasonable financial loss. It is anticipated that consideration will be given during the centennial year to presentation of these clinics in four or five communities in the state. Your Council on Scientific Work recommends that the House of Delegates express to the Council of the State Medical Society of Wisconsin its wish that the spring graduate clinics be continued and that a proper budgetary item be included to meet such minimum deficits as are necessary.

Wisconsin Medical Journal

An innovation in medical journalism was instituted by the WISCONSIN MEDICAL JOURNAL in the last year to prevent the smothering of current and original work in long reviews of the literature. In the past, almost every Journal article contained from one to five paragraphs in 10 point type devoted not so much to the authors' own work as to the laying of a foundation for it. In one sense such material is a synopsis to give the reader of a continued story the high lights of chapters that have gone before. Yet when it is published in the same large type as the new chapters, so to speak, it frequently starts articles with a deadly dullness; in addition it takes up considerable space. By placing all synopsis material in 8 point solid type and authors' original work in the larger 10 point type, better readability has been attained and more space allowed for scientific articles and for reporting the original work of Wisconsin physicians. The synopsis material is there for the physician who wants to read it, but the physician who has the "previous chapters" in mind can begin at once with the fresh material.

A definite effort has been made in the last year to incorporate in THE JOURNAL only articles of real and current interest to the profession. Dr. Karl H. Doege, Marshfield, medical editor of The Journal, has adopted definite criteria for acceptable Journal material. These include:

(1) Clinical truth and accuracy
(2) Importance of subject matter
(3) Number of times subject recently covered in Journal
(4) Value to Journal readers
(This test calls for the rejection of many specialty articles because they are not of particular value to the bulk of Journal readers, most of whom are engaged in general practice.)
(5) Length
(The preferred length of Journal papers is ten to fifteen pages in double-spaced typewriting.)

In furtherance of the State Medical Society's educational program, Dr. Doege has adopted the policy that the medical editor should take the necessary time and effort to advise authors frankly concerning the reasons for rejection of their papers or to suggest ways in which the article may be rewritten and made acceptable for publication. This policy, together with one calling for thoroughness and care in editing, occasionally means sacrifice of speed in notification of acceptance or rejection of papers, for the position of medical editor of The Journal carries with it no financial remuneration and the medical editor must carry out the heavy duties incident to the position in time aside from that required for his regular practice.

Dr. Doege's medical editorship has been characterized by keen judgment, a high sense of responsibility to his fellow practitioners in Wisconsin, and

an understanding of Journal problems which is the result of long years of work in the State Medical Society. The Council on Scientific Work commends the work of Dr. Doege as medical editor of The Journal.

COMMITTEE ON TUBERCULOSIS AND CHEST DISEASES

A. A. Pleyte, chairman, W. T. Clark, L. O. Simenstad

This committee has completed its first year of operation. Its function has been largely one of cooperation with existing agencies interested in the field of tuberculosis, specifically the State Board of Health, the Wisconsin Anti-Tuberculosis Association, and sanatoriums in the State.

The committee actively assisted the Wisconsin Anti-Tuberculosis Association in the early diagnosis campaign conducted during the month of April. The committee also cooperated with the Council on Scientific Work on questions of graduate medical education in the field of tuberculosis. The committee assisted in the development, preparation, and presentation of a series of ten institutes on chest diseases arranged exclusively for Wisconsin physicians. A complete list of these institutes appeared in the July issue of the Wisconsin Medical Journal on page 547.

4. REPORTS OF SPECIAL COMMITTEES

THE CENTENNIAL COMMITTEE

Robert W. Blumenthal, chairman, A. J. Patek, W. S. Middleton, P. R. Minahan, R. G. Arveson

The Centennial Committee of the State Medical Society has held one meeting to consider plans for the proper celebration of the Society's one hundredth birthday in 1941. All members of the committee were present and various suggestions were considered, among these being:

1. The dramatization of some of the outstanding events of medical interest occurring in the past century to emphasize progress.
2. Radio broadcasts.
3. Contests in councilor districts or otherwise, to stimulate interest and bring together relics of a medical note, such as photographs, instruments, records, etc.
4. The filming of the historic highlights of Wisconsin medicine.

The committee welcomes suggestions from interested members, since the possibilities are almost unlimited and this will be the only centennial celebration of the State Medical Society of Wisconsin in which any present member of our Society will participate.

ADVISORY COMMITTEE ON VOLUNTARY SICKNESS INSURANCE

(Because of its length, this report appears at the end of the annual reports. See page 659.)

COMMITTEE ON SAFETY ON PUBLIC HIGHWAYS

H. A. Heise, chairman, Millard Tufts, W. B. Cornwall

The committee held several meetings during the last year in an effort to correlate the medical problems involved in highway safety. It reviewed previous work on highway safety and reaffirmed the standards for visual acuity of automobile drivers established by a similar committee of the American Medical Association.

The present method of issuing driver's licenses was reviewed, and while the committee has not had an opportunity to study this as extensively as would be necessary in order to make a final recommendation, it does feel that driver's licenses should be issued periodically with perhaps a more effective physical examination being required than is now the case.

The committee likewise feels that the law should be made more stringent concerning the suspension or revocation of the driver's license for those apprehended and convicted for operating a vehicle while under the influence of intoxicating liquor.

The standards erected by the House of Delegates of the American Medical Association for determining whether or not a person is under the influence of intoxicating liquor were considered, and the committee feels that these are minimum standards and recommends further study of this question in the ensuing biennium, looking toward the possibility of introduction of legislation incorporating these minimum standards.

The committee obtained permission from the Council on Scientific Work for presentation of an exhibit at the present meeting of the Society. This exhibit will be found in booths 27 and 28 in the scientific exhibit section of the exhibit hall. The exhibit will show the medical factors involved in highway accidents, with demonstration of the blood and urine tests in popular use for determining whether or not the person is under the influence of intoxicating liquor.

5. REPORT OF COMMITTEE OF COUNCIL

CONFERENCE COMMITTEE ON OPEN PANELS

R. P. Sproule, chairman, T. J. O'Leary (representatives of State Medical Society of Wisconsin)

The Conference Committee on Open Panels, by mutual agreement, has two scheduled meetings each year. This committee is composed equally of representatives of the State Medical Society of Wisconsin and representatives of insurance companies.

Under the provisions of the open panel agreement, the duties of this committee are outlined in general, but the primary activity each year is to supervise the preparation of the panel of physicians available to treat compensation cases under the workmen's compensation act. The 1940 edition of the panel was distributed during the week of July 15

to all insurance companies licensed to write compensation insurance in Wisconsin.

The committee at every meeting has considered the question of listing of specialties on the panel. It has been the policy of this committee to list only the specialty of eye, ear, nose, and throat, the feeling being that the injured workman or his fellow workman is not competent to elect the proper specialist to treat the injury. However, the committee feels that if an injury occurs to the eye, ear, nose, or throat this is readily recognized by either the injured workman or the person in charge of first aid in the plant. The committee referred this question to the Council for advice, and this policy was reaffirmed by that body. The committee recognizes that there are some isolated inequalities through such panel listing, but believes the interest of the workman is served more advantageously through adherence to this policy.

Two other questions have been prominent in the committee's consideration during the last year. They are:

1. posting of the panel by industrial firms, and
2. professional relationships with the insurance carriers.

The workmen's compensation act was amended in 1939 to remove the previous statutory provision requiring that the employer post a panel of five physicians. The statutes now provide that the employer furnish a "reasonable" panel, but some employers still adhere to the policy of posting a limited panel or no panel whatever. In theory, where no panel is posted, the injured workman is permitted to choose his own attending physician. However, the committee feels that in actual operation the employe is not given an opportunity to exercise this privilege, and that the practical application of free choice of physician by the employe would more nearly approach the theoretical goal if the panel actually were posted in industrial plants. This has not been possible of accomplishment because of the costs involved. There are over 30,000 employers covered by the insurance written by standard insurance companies in the state, and thereto must be added many self-insurers. The cost of printing and distributing this panel would be considerable.

The representatives of insurance companies have placed before the committee rumors of unethical practice and alleged misconduct of physicians listed under the open panel, but it is difficult for the committee to obtain information of a sufficiently substantial nature to permit of investigation and action.

There are in Wisconsin several hundred industrial firms which avail themselves of the statutory privilege of carrying their own compensation insurance, that is, they fill the dual role of employer and insurer. An invitation was extended to these firms to participate under the open panel agreement, and a limited number elected to do so. The committee feels that the task of interesting self-insurers to operate under the open panel agreement is a slow educational process.

Second Annual Report, Advisory Committee on Voluntary Sickness Insurance*

IN THE pages which are to follow appears Part I of the second annual report of the Advisory Committee on Voluntary Sickness Insurance. Part 2 of the committee's report will be presented verbally before the House of Delegates on Tuesday night, September 17. The committee is composed of Drs. Robert W. Blumenthal, Milwaukee, chairman; C. D. Neidhold, Appleton; and Wellwood M. Nesbit, Madison.

This committee has completed its second full year of service to the Society. Throughout the two years in which it has been active, the committee has held at least one meeting each month to keep fully informed of the experimental work conducted under its immediate direction, and to hold study seminars on similar efforts of other state medical societies and on the broad subject of voluntary sickness insurance. Each of these men has given liberally of his time and has made real personal financial sacrifice to attend these meetings for which he has received no reimbursement. In addition to the regular monthly meetings of this committee, special meetings have been held to which were invited the chairmen of the advisory committees from the county medical societies in which the trials have been conducted. The committee also met with the Douglas County Medical Society at the halfway mark in the first year of service experience.

The Society is indebted to each of these members for the extended service he has rendered.

* Previous reports, Wisconsin M. J. Sept. 1939, p. 757; Feb., 1940, p. 134; March, 1940, p. 210.

MEMBERS OF THE ADVISORY COMMITTEE ON VOLUNTARY SICKNESS INSURANCE STATE MEDICAL SOCIETY OF WISCONSIN

Dr. C. D. Neidhold
Appleton

Dr. Robert W. Blumenthal,
chairman, Milwaukee

Dr. W. M. Nesbit
Madison

Each of the five sections of this first portion of the report deals with a separate subject and is set forth below in index fashion to permit ready reference.

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Section 1.—*Summary and Conclusions* 660

(This section of Part I of the committee's report is devoted to a brief summary of the findings and conclusions made by your committee, based upon the experience obtained through the trials conducted in Douglas, Milwaukee and Rock counties, and studies and observations of trials in other states.)

Section 2.—*Discussion of the Broad Aspects of Voluntary Sickness Insurance* 662

(In this section of the report will be found a definition of voluntary sickness insurance, the several methods that are used to enroll subscribers, the types of coverage usually written, the agencies from whom it is available, etc.)

Section 3.—*Voluntary Sickness Insurance Plans of Other State Medical Societies* 664a

(A brief resume is presented of the salient features of several plans for prepaid medical care offered by other state medical societies.)

Section 4.—*Factual Findings* 664

(A discussion of the findings disclosed by the several trials relating to solicitation, methods of selection, medical demands, etc.)

Section 5.—*Sickness Insurance of Standard Insurance Companies* 672

(This section of the report is devoted to a discussion of a related phase of the committee's work,—the sale of limited sickness insurance policies on a group basis.)

Part I

Section I

SUMMARY AND CONCLUSIONS

1. **Your Advisory Committee on Voluntary Sickness Insurance reaffirms the wisdom of the House of Delegates in authorizing experimentation rather than the establishment of permanent prepaid medical care plans.** The foresightedness of this procedure is evidenced in the material to follow by the fact that we have felt free to criticize the results of the trial plans, unburdened by a need to defend an accomplished plan from which no retrenchment was possible and which the profession itself, by establishing as permanent, would have in effect recommended as being a sound plan from both a medical and financial standpoint. In short, if the profession had established a plan on a permanent basis, it would have become the "recommended" or the "approved" system of prepaid medical care of the medical profession of Wisconsin. No commitment has been made by the profession on any of the trial plans, and therefore we feel free to report to you the actual results of our experimentation without thought of having to couch our findings in terms designed to make allowances or to gloss over shortcomings in order to avoid direct criticism of a "recommended" system.

2. **Your committee has found that experimentation in the field of voluntary sickness insurance is a desirable procedure.** Continued experimentation should be engaged in by the profession. This experimentation need not follow the pattern of laboratory

trials which have been conducted by this committee during the last two years; it may include a constant study of efforts being made elsewhere and authorization for actual experimentation when deemed advisable either by an interim committee or the Council of the Society. Continued experimentation in the field of voluntary sickness insurance is analogous to the constant and continued experimentation in medicine to find new drugs and new modes of treatment. We direct the attention of the House of Delegates to the heavy social responsibility of the profession to be ever alert to the development of new thoughts, discoveries, or studies, in the distribution of medical care. This consciousness of the social responsibility of the profession to the public which we serve has resulted in tremendous advancements in the past, and if pursued with the diligence that has exemplified medicine, will yield manifold benefits to the public in the future.

3. **Your advisory committee cannot report at this time that any of the three authorized experimental efforts are subject to wide application in their present form.** This statement is based upon conclusive findings disclosed by each of the three trials.

4. **There has been little, if any, spontaneous demand by the people in the three communities where voluntary sickness insurance has been made available through the three trial plans.** A similar exceedingly limited or restricted demand has been encountered in Washington, D. C., California, etc.

5. **The term "voluntary sickness insurance" is misleading.** It is a misnomer when applied to the subject of prepaid sickness care to the following extent: It is not voluntary in the sense that it is purchased when simply offered; it has been conclusively found that of necessity, prepaid medical care has to be sold,—it is not "just bought."

6. **The profession has considered its participation in the trial plans as a public service obligation.** The profession, as represented by the members of the State Medical Society of Wisconsin, has demonstrated its willingness in the three trial areas to cooperate with the public in suggested proposals for prepaid medical care. In actual trial, the attitude of the physicians has been reserved, unbiased, quiet and analytical. The approach has been that of a research student. No fanfare of enthusiasm followed the announcement of the trials in any of the communities, but rather, the attitude of the profession has been of a studious, earnest nature.

7. **The physical examination method of selecting subscribers to sickness insurance plans has been found not to be the method of choice.** Our studies have revealed that it is cumbersome, and does not result in a selection of superior risks. The public considers the physical examination, when a condition precedent to obtaining membership, as a "bother." To invoke this method of selection on a wide basis, and to be reasonably assured of a selection of superior risks, would necessitate the employment of specialists skilled in the field of underwriting.

8. **Subscribers to the voluntary sickness insurance trials did not request preventive procedures in any appreciable amount, even though the cost for this service was paid in advance.** Your committee concludes that preventive medicine must be "sold" to the public and that the alleged financial barrier in obtaining this service is not the deterrent.

9. **If there is a social justification for voluntary sickness insurance, the type of coverage written by standard insurance companies at the present time does not provide a service that would encompass a high percentage of our Wisconsin citizens.** The present coverage as to extent of the service for which these companies have agreed to indemnify, is not the extensive all-inclusive service generally conceived by organized medicine but is an exceedingly limited service. On the question of the approach to the problem, your committee can find no points upon which to take issue with the commercial insurance companies so long as they indemnify the employe–subscriber in *cash*.

10. **Those for whom it was stated that prepaid medical care plans should be erected, did not elect to obtain this type of insurance.** Those who purchased this type of insurance were not in the so-called lower income brackets. Those who were covered were essentially "substantial" citizens who in ordinary practice would not be confronted with serious difficulty in meeting their medical costs. The failure of those in the so-called lower income brackets to avail themselves of this coverage was due in large part to their lack of appreciation of the relative values of the protection and other expenditures. The cost of obtaining the protection was not beyond their ability to pay. If prepaid medical care plans are to reach those in the so-called lower income brackets, intensive and relentless sales and educational efforts must be directed to this particular group.

11. **Free choice of physician is actually and basically desired by the public participating.**

12. **It is not socially desirable to establish a large number of individually established and operated sickness insurance plans.** Plans such as those which were conducted on a limited trial basis by the county medical societies and the State Medical Society filled a social purpose. Should a plan of voluntary prepaid medical care be found which would be subject to wide application, our experimentation has demonstrated that a plan of the profession, no smaller than state-wide in application and control, would appear to be the most feasible. No social justification exists for the inherently high individual costs of establishing and operating plans with limited local application and with the inescapable separate overheads, supervision, studies and legal guidance. Individual plans operated under local aus-

pices either by the community, the medical profession or the public, carry with such sponsorship the danger of associating with that sponsorship any animosities that may exist locally.

13. **As stated repeatedly by the profession in earlier reports, prepaid medical care plans operated by private groups, whether they be lay or professional groups, are so fraught with major public health dangers as to make them exceedingly undesirable.** Your committee recommends that this House of Delegates again expresses its disapproval of prepaid medical care plans operated by private groups of physicians or private-public groups. *This recommendation is based upon the fact that private profit-seeking groups are concerned primarily with their financial returns and not with the health of the subscribers.* We have been unable to find, on investigation, any private prepaid medical care plan in the United States which is self-supporting on subscribers' dues alone; the private prepaid medical care plans depend upon fees obtained from private practice outside the prepaid plan and upon profit made from the sale of drugs, appliances and other items. There is danger, where private prepaid medical care plans are established and competition exists, of promising the public to deliver "more for less," with the inevitable result that the service to the subscriber is cheapened without his knowledge. This danger would become a certainty were there to be established numerous and competing private plans.

14. **It has been found necessary to exert extensive collection efforts to keep policies, or subscriber contracts, in force where collection of premiums is on an individual basis.** An exception to this finding might possibly be found when the payroll deduction method is employed.

15. **Wisconsin citizens, as represented by the subscribers participating under the plans are now receiving needed medical care.** An exceedingly high percentage of those applying for participation in the plans stated that they did not have any known medical needs. This is substantiated by the fact that there were no heavy demands made immediately after the inauguration of the plans to care for deferred medical needs.

16. **Any plan of voluntary sickness insurance, to be successful, must have not only the approval of the physicians, but their active and enthusiastic support as well.**

17. **There has been comparatively little demand for prepaid medical care plans from the profession. Such efforts as have been made have generally arisen in response to an apparent public demand.** This is evidenced not only in Wisconsin, but in other states where prepaid plans for sickness care have been inaugurated. It has been found that an organized effort must be made to enlist a majority of the eligible physicians to become "panel physicians" under these prepaid plans.

18. **Your committee has found that under voluntary sickness insurance a small percentage of the physicians render a high percentage of the service.** The subscribers are not equally distributed among all of the physicians participating under the plan. Your committee concludes then, that voluntary sickness insurance does not hold any promise of distributing equally among physicians all of the demands of subscribers. The busy physicians will continue to be busy, and the unoccupied physicians will continue to be unoccupied.

19. **After careful study, your committee concludes that a policy of joint ownership or subletting to other organizations, corporations, associations or others the necessary sales effort involved in obtaining subscribers to voluntary sickness insurance plans, contains many inherent dangers which at the present time do not appear possible of elimination.**

20. **Participating physicians under the trial plans have not elicited from subscribers under the plan, information of a social character which they have not been accustomed to obtain in the past.**

Section 2

BROAD ASPECTS OF VOLUNTARY SICKNESS INSURANCE

Definition. Voluntary sickness insurance is an insurance structure whereby, through established periodic voluntary payments to a common fund or agency, the individual or the group is insured against certain specified costs contingent upon illness either by cash indemnities or by service.

Voluntary sickness insurance may be offered through several agencies. The following suggest a few of the numerous possibilities: (1) stock and mutual insurance companies, (2) state or county medical societies, (3) groups of physicians, (4) individual physicians, (5) groups of people, and (6) the government.

There is an unlimited number of types and degrees of coverage that these groups or agencies may offer. This may vary from a complete coverage type of policy or agreement in an unlimited amount, to a type of policy which pays or insures against an extremely limited number of sickness cost hazards. Such plans are in fact insurance and must conform to statutory provisions and insurance laws.

Insurance Concepts of the Medical Profession.— Generally speaking, it has been the concept of the medical profession in Wisconsin that if any insurance system could be evolved that would permit wide application without sacrifice of high medical standards, it would be an insurance program which insured the individual or the group against *all* of the physician's costs that might be encountered during a given period. This coverage would be unlimited both as to *type* of services to be rendered and the *quantity* of service that is to be obtained. This type of insurance protection can be offered most effectively by a medical society wherein the physician is,

in fact, the insurer; that is, the physician agrees to render an unlimited amount of professional service for a specified periodic payment.

A second type of coverage for sickness care would be that type which is limited in scope, but not *intentionally* limited so far as quantity is concerned. This type of coverage is that which has been offered in some areas by an individual physician insuring a group of individuals or families for all of the medical care that he can render. This type of coverage *is* limited, however, because of the professional limitations of the individual physician, and is also limited in quantity of medical care that can be rendered because of the physical limitations of the individual physician.

Prepaid medical care plans offered by physicians where the reserves are the abilities of the private physicians to deliver the service, have many inherent dangers. If such plans or insurance programs are permitted, a number of safeguards should be established, the minimum of which should be those safeguards established by the Special Committee to Study the Distribution of Health Services and Sickness Care in Wisconsin, as contained in the report adopted by this House of Delegates in September, 1938. A few of the inherent dangers of privately established prepaid sickness care plans are:

1. They are motivated by the profit that will accrue, rather than primarily by the service which will be given to the subscribers.

2. Plans by private physicians, as they have been offered in the United States, are not of themselves self-supporting,—they are dependent in a large measure upon professional fees obtained from private practice which is performed *in addition* to the services which are included under the contract or which are in addition to services rendered to subscribers; they also depend upon profits made from the sale of drugs, magazines, cosmetics, candy and other subsidiary items. There is the further danger that that which is promised to be given is not clearly stated to the subscribers, and the subscribers find that they are required to pay for extras such as fees for confinements, fractures, refractions, house calls and similar items.

3. Where competition exists between privately owned plans, there is an incentive for each plan to promise to the subscribers more services than the others for less fees. This has always resulted in an inferior type of service being rendered to the subscribers.

Commercial Insurance Companies. — A type of sickness insurance coverage which has come into prominence particularly during the last year has been that type of coverage which is offered on a group basis to employed groups by regularly licensed standard insurance companies. Generally speaking, this type of coverage has been limited in its extent to cash benefits covering specified surgical procedures, limited in amount to a total of $150 for the policy year.

The insurance offered by the standard insurance companies is designed essentially to reach large employed groups. The group policies as offered in Wisconsin at the present time do not take employed groups of less than fifty in number, and 75 per cent of the group must elect to purchase the insurance. Thus, there is immediately excluded from coverage a large section of the Wisconsin citizenry such as the farmer, the independent contractor, the independent merchant, domestic servants, etc. The policies as issued by insurance companies offer to indemnify for certain specified surgical operations. Those operations which are not specified are not generally covered. The coverage is written to reach only the employe. It is the exception rather than the rule that dependents are covered, even for surgical benefits. None of the commercial insurance companies write a group medical policy which covers home and office care and similar services.

The professional problems which are raised as a result of treatment given to employes covered by this insurance are national in scope. An attempt was made to discuss the several problems with representatives of commercial insurance companies through their respective associations, the American Mutual Alliance and the Association of Casualty and Surety Executives. We were, however, unable to arrange such a conference.

A more complete discussion of this phase of our studies will be found in Section 5 of this report, which begins on page 672.

Deductible Insurance. — The deductible type of coverage was originally conceived in our own state by a committee from the Medical Society of Milwaukee County. This type of sickness insurance appears to hold favor among the medical profession, for it is becoming an increasingly common feature in prepaid sickness insurance plans devised and offered to the public by the medical profession in other states. Under this type of coverage the insured person agrees to be a partial insurer, that is, he promises to pay for his first medical needs in addition to the stipulated premium cost paid to the insurance fund. The insurance is similar in its application to the deductible automobile insurance. One point of differentiation, however, is that usually under *medical insurance* the insured person pays the deductible amount only *once* during the course of a year whereas under automobile insurance the deductible amount is paid for *each* accident.

Individual Health and Accident Policies.—A still different type of coverage is that which is offered on an individual basis by standard insurance companies. Under this type of coverage the insurance company selects its risk either on a combined history and physical examination basis or on the exclusive basis of a history. Here, however, the insurance company elects to offer one of two common types of coverage,—either a specified indemnity in dollars for time lost, or reimbursement for medical care based upon certification of services rendered

by a physician. A policy limited in its benefits to certain specified surgical procedures is a more popular type of coverage among insurance companies. This type of coverage is elected because of the facility with which the insurance company can ascertain that the services were rendered and for the reason that when surgical care only is offered, the possibility of unnecessary demands being made is reduced to a minimum.

Medical Society Efforts. — Your State Medical Society has experimented in the field of voluntary sickness insurance during the last two years. There have been three separate trial efforts. Each trial plan owes its existence to the incorporation and the subjection to trial of basically different insurance and social problems. Each trial which your committee has authorized during the last two years has had incorporated in it features which the committee felt have made these plans fall as closely as possible into the physician's concept of what constitutes a laboratory experiment. Each trial has had incorporated in it controls and limitations which your committee established to make the plans in fact an experiment. The three established trials in Wisconsin conform to the precepts outlined by the House of Delegates when it adopted, in 1938, the report of the Special Committee to Study the Distribution of Health Services and Sickness Care in Wisconsin.

Each of these trials will be discussed separately in the section to follow. The voluntary sickness insurance features of each, however, will be discussed at this time. The Douglas county experiment owes its existence to the fact that it subjected to laboratory trial the *individual method of selection* based upon a physical examination, and to the fact that the plan was conceived and operated by a lay group. The second trial, assigned to the laboratory of Milwaukee county, owes its existence to the following facts: It subjected to trial the deductible insurance principle; it was conceived and operated in its entirety by a county medical society; and, as a third distinguishing feature, the selection of risks was on a group basis. The trial plan in voluntary sickness insurance offered in Rock county was designed to provide unlimited service without any additional financial responsibility on the part of the covered person other than the payment of premiums (full coverage), and to select the risks on a small group basis (minimum group to be accepted was ten).

Elsewhere in the United States during the last year state medical societies have entered the field of voluntary sickness insurance on a state-wide basis. Several states have obtained special permissive legislation which allows the state medical society to engage in this field of activity, usually under the supervision of the commissioner of insurance but without the establishment of the customary reserves or being required to meet the legal restriction of the practice of medicine by corporations. Plans for prepaid medical care are in actual service operation in Michigan and California, and possibly Utah. The state medical societies of Pennsylvania, New Jersey, Connecticut, New York, Colorado, Massachusetts and Texas have a "paper plan" in various degrees of development but not yet in service operation. The District of Columbia had a deductible type of prepaid sickness insurance which was offered to the public but did not find sufficient groups interested to warrant operation.

The distinguishing features of a few of the several plans are set forth in the special chart constituting section 3, to be found facing this page.

SECTION 3

VOLUNTARY SICKNESS INSURANCE PLANS OF OTHER STATE MEDICAL SOCIETIES

(See chart facing this page)

Section 4

FACTUAL FINDINGS

Preface.—The committee called into conference on two occasions the chairmen of the local committees in charge of the trials to discuss progress and future policies. We have conceived the limitation of our authority to terminate at this session of the House of Delegates. It was the intent of this committee to so arrange the term of the experiments as to have them possible of termination, if then in operation, when this House of Delegates met, deliberated and arrived upon a decision. The experiment in Milwaukee county obtained its first service operating unit (Greendale) on November 1, 1939. Under the provisions of the contract, the plan was to remain in operation for a trial period of one year. Thus, so far as the contract itself was concerned, the trial would be possible of termination on November 1, 1940.

We realized early in 1940 that we would be faced with the problem of fulfilling contracts long after this House of Delegates had made its determination of the future of these trials. Consequently, at the first meeting of the chairmen of the committees in charge of the trials, an agreement was reached that no new units would be accepted under either the Rock county plan or the Milwaukee plan after May 1, 1940.

The trial plan in Superior terminated its first full year of service operation on June 30, 1940. We were satisfied that by the time the first full year of service operation of the plan had been completed, sufficient experience would have been acquired to permit us to make our report to you. The officers of the Cooperative Health Association, however, were faced with a practical problem, namely, a determination for a reasonable period as to collection of premiums from subscribers for the months to follow June, and a determination of whether there would be any permanent continuation pending action of this House of Delegates. The officers of Cooperative Health As-

SECTION 3.—VOLUNTARY SICKNESS INSURANCE PLANS OF OTHER STATE MEDICAL SOCIETIES

State in which plan operates	Name of plan	Area affected	Selection of risks	Smallest group accepted	Percentage of group required for membership	Eligibility	Types and extent of coverage	Deductible? If so, what are the stipulations?	Maximum benefits obtainable per year	Benefit exclusions	Premiums	Number of members of state medical society participating in plan	Total number of members in state	Number of non-members of state medical society participating	Estimated total number of non-members in state	Number of subscribers and date of figure	Acquisition of subscribers	Sales organization located in how many communities (in the state)	Salesmen employed	Results of how many months' effort?	General comments
MICHIGAN	Michigan Medical Service	Entire state	Primarily groups	25 or more	No. in group / Complete Physician Coverage / Surgical Coverage 25—49 / 90% / 50% 50—99 / 80% / 50% 100 or over / 75% / 50%	Individual income not exceeding $2,000. Family income not exceeding $3,000. (Those with larger incomes are eligible for coverage but the physician is privileged to charge the patient a fee in addition to the membership fees.)	1. Complete physician coverage. 2. Surgical coverage only.	$5 payment for needed care during a one-year period. No deduction made under surgical policy.	1. **Medical:** $325 worth of medical services for an individual $550 worth of medical services for husband and wife $375 worth of medical services for a family. 2. **Surgical:** $150 per family or individual, including series of operations for same cause.	Dental care, nursing services, drugs, appliances, hospitalization.	1. **Complete physician coverage:** Single person—$2 Husband and wife—$3.50 Family—$4.50 2. **Surgical coverage:** Single person—40c Husband and wife—$1.20 Family—$2	3,054	4,262	112 applications have been filed.	2,102	May 31, 1940: Surgical benefit plan, 61,783* Medical service plan, 1,352 (*58,009 represented by Ford Motor Company.)	Michigan Society for Group Hospitalization also acts as sales agency for Michigan Medical Service.	9	16	4	Distribution of participating physicians according to county location and type of service, compares closely with distribution of total number of physicians in practice. In first three months of operation medical and surgical bills totaling approximately $50,000 were paid on behalf of more than 1,200 patients. Income was sufficient in each of the first three months to pay physicians for services rendered, to cover all administration expenses, and leave a small net balance. One out of every fifteen physicians in Michigan has received some payment through this plan for services rendered to subscribers. It is pertinent to note that 58,000 out of the 61,783 surgical benefit policies in force were issued at one time to employees of the Ford Motor Company. Sixteen representatives working four months have been able to place only 1,200 medical service policies (complete coverage).
CALIFORNIA	California Physicians' Service	Entire state	Groups only	Employed groups of 5 or more	100%, in smaller groups; ranges down to 40% in larger groups.	Members under age 66 years, with family income of $3,000 per year or less, receive service without additional payment.	1. Complete medical, surgical and diagnostic coverage. 2. Deductible coverage. N. B.—Hospital insurance is also offered.	Under deductible coverage patient pays for first two visits to physician in any one sickness.	1. Complete coverage: No limit placed upon the services needed except that services provided up to one year's care for each disease or injury. 2. Deductible coverage: No limitation except for payment of first two visits of physician. Same limitations as complete coverage policy otherwise.	No x-ray, pathologic or anesthetic services included in hospitalization policy.	Complete medical, surgical and hospital coverage, $2.50 per month *per person* Deductible coverage, $2.00 per month *per person* Physician's services only, $1.70 per month *per person*, under full coverage membership Physician's services only, $1.20 per month *per person* for deductible coverage.	5,188	6,542		5,367	14,840 on July 1, 1940	Membership solicitation activities are carried on jointly by Physicians' Service together with two nonprofit hospital service associations in the state.	2 (3 salesmen in southern part of state; 2 salesmen in northern part of state.)	5 (representatives of 2 hospital associations also offering the plan.)	10	As this analysis is written it is significant to note that this plan does not offer a family coverage policy, but that each member of the family must pay the same premium. After approximately 10 months of solicitation by five special representatives and the representatives of the two hospital associations, 14,000 subscriber contracts are in force. Subscribers to hospital service are, of course, for in excess of the number subscribing for medical service. This plan is not self-supporting. It had a large initial loan from the California Medical Association and after almost a year's operation it secured authorization from the House of Delegates for additional funds. The costs of maintaining the sales organization are underwritten jointly by the California Medical Association and the two hospital associations.
NEW JERSEY	Medical Service Administration of New Jersey	Entire state eventually. Two counties first year for experimentation	Groups only	10 or more	No. in group / % 10—20 / 100% 20—50 / 90% 50 or more / 60%	Individuals under 65 years of age without physical examination. If over 65, physical examination is required. Single persons limited to income of $1,000 annually; man and wife, $2,000 annually. $200 added for each child or dependent.	Complete coverage.	Not deductible.	$250 for single person during any contract year. $500 for family during any contract year.		Computed on income basis: Subscriber—½% of monthly earned income plus 75 cents 1st dependent—1½% of subscriber's monthly income, plus 50 cents 2nd dependent—½% of subscriber's monthly income, plus 25 cents Additional dependents—¼% of subscriber's monthly income, plus 25 cents	Plan restricted to two counties only		Plan restricted to two counties only		Plan is still in formulative stage. No subscribers enrolled as yet. (July 15, 1940)	Medical Service Administration which is state-wide will administer the plan. Method of acquisition of subscribers not clearly determined.				The Medical Service Administration, so-called, will be state-wide although the plan proper will be restricted to two industrial counties for an experimental period of one year. Groups, otherwise ineligible, may be accepted with the approval of the board of governors. The Medical Service Administration will operate the Farm Security plans in New Jersey beginning in the fall of 1940. Method of adjusting subscription rates may have to be altered for industrial groups so they will be based on average income of the particular group involved. No deductible provision was provided because it was deemed to promote consultation of patients with physicians only in disease and it was felt that a deductible provision would hamper this effort.
NEW YORK	Medical Expense Fund of New York, Inc.	Entire state. Enabling law limits any group to a maximum of 18 counties.	Groups or Individuals	5	75%, if group type is taken. (Individuals must have physician certificate of freedom from impending need for care.)	Any person living within confines of one of the established areas, regardless of income.	Deductible policy only.	Yes. Deductible amount varies with income, from $8 to $10 per policyholder.	Vary from $200 to $400, depending upon the premium paid.	Services covered under workmen's compensation; elective surgery; venereal diseases during first contract year; nervous and mental diseases; malignancies diagnosed during first six months; obstetric services during first contract year; military and naval services; services rendered during ailment known to exist prior to application; self-inflicted injuries, and those resulting from lawlessness.	Based upon ability to pay annual premiums: Monthly Income With Dependent / Monthly Income Without Dependent / Group Annual Rate / Individual annual rate / Deductible sum Over $175 / Over $125 / $15 00 / $17 00 / $10 00 $175—$140 / $125—$100 / 12 60 / 15 00 / 10 00 $140—$100 / $100—$75 / 10 80 / 12 00 / 7 50 Under $100 / Under $75 / 9 00 / 10 00 / 5 00	After one month's enrollment efforts $70 members signified a willingness to participate	16,500		10,410	Plan not yet in service operation. It is not anticipated that it will be placed in operation until September 1, 1940	Sales of policies will be made through the group hospital insurance sales force in New York.	Each community has its own plan, and probably will have its own sales organization.	Number unknown. Present indications are that the sales organization of group hospitalization will be used	Plan not in actual operation	On the surface, this plan would appear to be a cash indemnity plan and it gives the appearance of paying the subscriber in cash. In actual operation, according to information circulated to the profession, the "underwriting member" (participating physician) agrees to render service and agrees to accept reimbursement based upon unit value. The unit value will be computed on the basis of the amount of funds available as compared to the services rendered. This plan might be considered a cross between the small county plan and the state-wide plans of Michigan, California, etc. The statute provides that no one group shall embrace more than 18 counties.
UTAH	Utah Medical and Hospital Benefit Association	Entire state	Individuals in groups which have chosen a remitting agent for all members of that group.	10	No. in group / % 10 / 100% More than 10 / 75%	Individuals in good health, under 65 years of age, including dependent single children living at home, if under 19 years of age.	Schedule of reimbursement is based upon a list of reimbursable services; 70 specific reimbursable items are listed.	Not deductible	$100 in any one year for any one member or dependent. $300 in any one year for any family.	X-ray, laboratory and other special services excluded, unless specifically listed.	Number of persons / Monthly / Annually One / $1 00 / $10 50 Two / $1 75 / $18 00 Three or more / $2 25 / $24 00	Actual cash indemnity policy—no panel established; physicians need not indicate participation				None	No subscribers have been acquired or indication given that salesmen, as such, will be employed for this purpose.		No actual sales force employed	4	This plan is a nonprofit, mutual benefit corporation, organized under the insurance laws of the State of Utah and therefore under jurisdiction and control of the state insurance department. This plan is in fact a cash indemnity one. Reimbursement does not cover costs 100 per cent, but is intended merely to "cushion" these costs for the low wage earner. Plan, after four months, has enrolled no actual groups, although some groups have considered or are considering the plan.

sociation asked for a continuation of the agreement for another full year. However, we authorized extension of the agreement to January 1, 1941, only. This period of time was selected in order to permit this House of Delegates to meet and to allow the officers of the Cooperative Health Association, after this House had met, properly to advise their subscribers that the plan either would be continued or discontinued, based upon the joint action of this House and the members of the Douglas County Medical Society.

DOUGLAS COUNTY
(Cooperative Health Association)

A plan for prepaid medical care as conceived, organized and managed by a lay group. Contract provisions, premiums, benefits, exclusions and similar items accepted by the profession "without expression of judgment." Membership open to any resident of Douglas county. Premiums established by lay group, $2.90 per month per family; $2.25 per month for man and wife, and $1.50 per month for single person. Each person applying must make written application giving medical history, and must submit to and pay for a special physical examination. Subscriber eligible for complete physician's care without limitation as to extent and quantity.

Date of service operation of plan.—This plan was placed in actual service operation on July 1, 1939.

Method of selection.—Any individual or family residing in Douglas county was eligible to participate in the plan. Subscribers were selected by individual physical examination. Each person making application for admittance as a subscriber to the plan was given a physical examination by one of the participating physicians. The officers of the Cooperative Health Association established the rate of $2 for the first examination, and $1 for each additional examination in the family, with a maximum of $5 for a family. Payment to the physician on this basis averaged from $1.06 to $1.30 per examination. Extent of the examination was greater than the ordinary life insurance examination. Upwards of 600 individuals were examined under this provision of the plan. Of the 600-odd individuals examined, it is significant to note that no applicants were refused. Some applicants were accepted with limitations and a rider placed upon their policies excluding benefits for certain specified illness or physical defect; i.e., an applicant found upon examination to have a hernia was excluded from having this repaired under the plan. Similarly, if an individual was found to have markedly diseased tonsils, tonsillectomy was excluded as a benefit under the plan. This method of selection is one of the accepted means of eliminating poor risks under health and accident insurance. It was found that the method of selection was an obstacle to enrollment of subscribers. Even though the examination was performed at a most reasonable figure and below cost of rendering the service, some subscribers hesitated or declined to join because of this initial hurdle in cost. A physical examination program, in order to function properly, should incorporate a review and study of the completed examination blanks by an experienced medical underwriter. There is nothing to indicate that the physical examination method of selection results in any better selection of risk than does a group method of selection.

It was found that even after the examinations had been paid for, the subscribers procrastinated in obtaining their examinations, sometimes over extended periods. The fact that rather prolonged delays occurred between the time these families paid to the association the examination fees and the time these examinations were performed, indicates that the so-called financial barrier in obtaining medical care is not the only barrier. The indifference on the part of the individual would appear to be one of these so-called barriers.

Solicitation. The executive committee, the manager and special subscriber committees exerted extensive effort continuously to enroll new subscribers to the plan.* After exhausting all means of solicitation which occurred to the executive committee, the manager and others, the executive committee of the association issued a call for a meeting of the subscribers and implored their aid in enlisting new subscribers to the plan. A special committee of members of the association, known as the "drive committee," began extensive solicitation efforts in January, 1940, and continued their efforts through April, 1940. A material increase in the number of subscribers was obtained through this effort, but the number enrolled still was far short of the maximum of 300 subscriber units. Your committee's study of this plan discloses that no meritorious claim can be lodged that disinterested efforts of solicitation were employed. It was found by this committee that exhaustive sales efforts were employed by the officers of the association, the "drive committee" and the manager. Some efforts of the drive committee might be considered coercive, so far as cooperative employes were concerned. The month by month solicitation record is set forth below:

Month	Number of subscribers	Membership Gain or Loss
July, 1939	138	*
August	143	+5
September	148	+5
October	150	+2
November	163	+13
December	162	—1
January, 1940	159	—3
February	184	+25
March	215	+31
April	226	+11
May	232	+6
June	235	+3
Total 12-months gain		97

* Month plan placed in service operation.

Type of subscriber.—The application blanks signed by the subscribers requested a statement of their

* For a summarization of solicitation efforts made prior to placing the plan in operation, see Wisconsin M. J. 38: 772 (Sept.) 1939.

annual income. It was found that 51 per cent of the subscribers fell in the income group of $1,200 to $2,250. Only 25 per cent had incomes of $1,000 or less. An investigation made through the credit bureau of the city of Superior disclosed that the subscribers were of the "prompt pay" class. No subscriber appeared to have any unpaid judgments registered against him, and only one subscriber among those checked had an unpaid physician's bill. The committee found upon studying the credit reputations of some fifty-seven subscribers that they definitely could be placed in the category of substantial, honest, reliable people, of moderate income. They were for the most part people in the comfort level of society.

Demands.—Contrary to expectation, no immediate deluge of demands for medical care was witnessed. No marked demands were made upon the service until the sixth month of operation. The demands made upon the plan during the first six months were essentially for the ordinary type of office call which the average physician encounters in his everyday practice. Surgical procedures under the plan were not a factor of any moment until the ninth month of service operation. During the ninth month, the demands upon the plan for surgical services suddenly mounted, permitting payments to participating physicians of but 58 per cent of their minimum normal fees.

There was no marked nuisance demand on the physicians for care. Only one case appeared to fall in this category and it was found upon investigation that virtually identical demands were made by this one subscriber prior to being covered by the Cooperative Health Association.

Proponents of voluntary sickness insurance have repeatedly emphasized the tremendous value that was to be found in prepaid medical care wherein preventive medicine would be available and used by a high percentage of the subscribers. It was found that during the entire initial year of operation, only 10 immunizations were performed, and only 9 vaccinations were performed. This represented less than 10 per cent of the *children* under 20 years who had not received these preventive procedures prior to the time the plan was placed in operation. Grouping under the general classification of preventive medicine such items as monthly pediatric consultations, physical examinations where no complaint was registered, immunization and vaccination procedures, and whooping cough inoculations, preventive measures represented only 2 per cent of the total demands made upon the plan.

There is no evidence to indicate that pregnant women consulted the physicians earlier under the plan than prior to its inauguration. It is to be noted in this connection that prior to inauguration of the plan, physicians were consulted during the first two months of pregnancy by over 60 per cent of the subscribers. By the third month of pregnancy, over 81 per cent had consulted their physicians.

Distribution of requests for service among physicians.—A study of the demands made by subscribers under the plan with relation to the physicians discloses that a small percentage of the physicians performed a high percentage of the service. Eighteen per cent of the participating physicians performed 49 per cent of the service. Below appears a chart showing the percentage of service rendered by the individual participating physicians:

Physician	Percentage of total services rendered
A	15.3
B	12.6
C	11.1
D	9.5
E	9.4
F	5.7
G	4.8
H	3.3
I	2.2
J	1.9
K	1.7
L	1.6
M	1.5
N	1.3
O	1.3
P	1.2
Q	.8
R	.5
S	.4
T	.2
U	.09
V	.03
Y*	8.12*
Z**	4.31**

* This represents the percentage of the total amount of service which was rendered by physicians residing outside the territorial limits of Douglas county. Subscribers to the plan were permitted to be referred to physicians outside Douglas county or if they became ill while out of the county they were provided with reimbursement in the amount which the local physicians would have been paid for the same service.

** Grouped in this classification are non-physician participants, such as the hospitals and the x-ray laboratory.

Physicians' claims.—Physicians' claims, almost without exception, were submitted in conformity with community practice. It was rarely necessary for the local committee to exercise its discretionary power to adjust bills to conform with community practice. When this was necessary, it was due to a misunderstanding on the part of the participating physician. The local advisory committee was convinced in only one instance that unwarranted statements were submitted.

Payments to physicians.—Eighty per cent of the subscriber income was earmarked for physicians' services. On this basis it was possible for the association to make payments to physicians based upon the minimum normal charges made in private practice in the following percentages during the year:

First quarter	86 per cent
Second quarter	84 per cent
Third quarter	58 per cent
Fourth quarter	69 per cent
Average for twelve months	71 per cent

If this plan had been required to be entirely self-supporting and had not received administrative contributions from the State Society to make up the difference between the administrative funds (obtained by allocating 20 per cent of the subscribers' dues to a separate fund) and the actual month by

month administrative costs, from the State Medical Society of Wisconsin, it would have been possible for them to pay but only 55½ per cent of the normal schedule of fees.

Computation of self-supporting premiums based upon Douglas county experience.—As a preface statement to consideration of the premiums computed on experience obtained in Douglas county, it is to be noted that no plan computes its premiums on the basis of anticipated actual costs of the various types of units covered, but rather on a combination of what the traffic will bear, relatively speaking, by the single units, couples and families. For instance, it was disclosed that the cost of caring for a family was in excess of four times that for a single unit. The table shown below indicates premiums necessary (based on the Douglas county experiment) to be charged the various types of units where each bears its *proportionate* share of the actual cost of rendering care. In other words, each type of unit premium is computed on the basis that it would be self-supporting of its own accord. It is to be noted that the premiums set forth below are "pure premiums" (include only physician service costs) and do not include any amounts for overhead or acquisition of subscribers.

ESTIMATED PURE—MONTHLY—PREMIUMS
(No administrative costs included)

	Complete physician coverage	Complete physician coverage after payment of first $5 during the year	Complete physician coverage after payment of first $10 during the year	Complete physician coverage after payment of first $25 during the year
Single	1.58	1.39	1.23	.91
Man and wife	3.48	3.06	2.72	2.01
Family	5.71	5.01	4.45	3.29

Committee summary comments, Douglas county.—1. The trial plan in Superior has disclosed beyond any reasonable question the fact that there is an exceedingly limited demand for the proffered prepaid medical care. Certain it is that of the three trials, the most extensive and intensive solicitation efforts were used in Superior to obtain subscribers. During the past year, at a time when the plan was in actual service operation, the Cooperative Health Association has been able to increase its membership by only 100 subscribers. A detailed summary will not be made here of the numerous solicitation efforts used, but the following are indicative: The association offered to waive a month's dues in the association for every ten new subscribers brought into the association by present subscribers; public meetings were scheduled with the Farm Security Administration; radio addresses were made; personal solicitation efforts were made by a special "drive committee," the manager, and members of the executive committee.

Your committee is impressed with the fact that this particular type of prepaid insurance policy offered by a local community group is not the method of choice in offering or selling this type of insurance.

2. Widespread duplication of an individual plan such as the one in Superior would be possible only if there were large reserves of cash from which no service would be expected or no refund or cash return was anticipated or if each subscriber was assessed an initiation fee in addition to the first application and premium costs. Based upon the experience in Douglas county, including the actual cash which has been advanced by the Cooperative Health Association and the State Medical Society of Wisconsin, together with advances in the form of printing, supplies and legal services, it would have been necessary to have charged an initiation fee of $15 per subscriber unit. Based upon actual cash advances by the Cooperative Health Association and the State Medical Society, it would have been necessary to have charged an initiation fee in excess of $10. This, however, would not be a true index, as it would leave sponsors of such plans without services that are essential to protect the subscribers, the officers of the association and the physicians.

Your committee recognizes that there is a question in the mind of each member of the Society as to why this prepaid plan was not received with more pronounced demand than has been evidenced in Superior. The reasons given by individuals who were approached for participation were essentially economic in nature. They were:

a. A lack of proper appreciation or evaluation of the comparative value of prepayment or budgeting for medical care and other budget items or prepayment obligations as radio, appliances, automobiles and others.
b. Physicians' services during the past several years have not averaged the premium costs ($36).
c. The subscribers stated they did not have funds.
d. The prospective subscribers felt that the premiums were too high.

3. The physical examination method of selecting subscribers at the outset appeared to be a sound method of selection. Our studies have revealed, however, that in practical operation it is not a particularly workable method of selecting subscribers.

4. Contrary to the opinion and prediction expressed in 1938 by some of the cooperative leaders to the Special Committee to Study the Distribution of Health Service and Sickness Care in Wisconsin, the receipts by physicians under this prepaid plan were below what the same physicians would have received from the same subscribers in private practice. The patients who are subscribers under this plan are the type of citizens who pay their obligations to the physician in full. There would be no collection loss approximating the loss taken by the members of the Douglas County Medical Society from the Cooperative Health Association. It is similarly significant to note that the percentage return to the physician indicates a progressive decrease each succeeding quarter rather than an increase.

MILWAUKEE PLAN

The distinguishing feature of this plan is that it has a deductible amount which must be paid to the physician direct before benefits can be obtained by the subscriber from the insurance fund. Each subscriber unit, whether single, couple or family, is required to pay to a panel physician $24 before becoming eligible for services under the plan. After the payment of the initial $24, subscribers are entitled to an unlimited amount of physicians' care throughout the year so long as their dues or premiums are maintained. Subscribers may choose their own physician from a panel of from 450 to 500 physicians.

Date of service operation of plan.—This plan was placed in actual service operation on November 1, 1939.

Method of selection.—Subscribers were selected under this plan on a group basis. The percentage of the group required to join varies from 33⅓ per cent of subscribers to 50 per cent or more. No physical examination was required of those participating.

Solicitation.—Since the announcement of the plan on April 8, 1939, a citizens' committee at Greendale, a Federal Government Housing Project, located near Milwaukee, has conducted an extensive solicitation campaign among the residents of Milwaukee county. It was not until late in the evening of November 1, which was the final date set by the Medical Society of Milwaukee County for placing the plan in operation, that the committee was able to secure the required minimum of 200 subscribers at Greendale, where nearly 600 families reside. Here, as in Douglas county, the citizens' committee has exhausted every means to induce residents at Greendale to participate in the plan. It was fully anticipated by the citizens' committee that once the plan was placed in operation many additional subscribers would join.

At Parklawn, a second government housing project in which resided approximately the same number of families as resided at Greendale, a citizens' committee formed there worked for upwards of six months in order to enroll subscribers in the plan. After extensive effort this citizens' committee forwarded the following communication to the Medical Society of Milwaukee County:

September 23, 1939.

To: The Medical Society of Milwaukee County,
Mr. Ralph Weber, Ass't Secretary.

Dear Sir: The Medical Society Committee of Parklawn wishes to notify you of the following recommendation, made by the committee, to wit: Whereas, the committee has been at work, for as long as six months, endeavoring to obtain subscribers to the Sickness–Insurance Plan, offered by the Milwaukee County Medical Society to the tenants of Parklawn and Greendale, and has found the majority of such tenants of Parklawn unresponsive to any such plan, actually signing only fifty (50), of the required 170 families, the Committee, with the welfare of these fifty families, (and also the work and time of the Committee itself) in mind, recommends:

That the group of Parklawn tenants who wish to enter this plan be allowed to join the Greendale group already entered, under terms satisfactory to both groups, or:

That the Medical Society of Milwaukee County make some provision for the Parklawn group, in view of their willingness to participate in this untried plan.

The Medical Society Committee of Parklawn will be ready and willing at any time to meet with the Committee appointed by the Milwaukee County Medical Society.

Very truly yours,
Ruth Hlawek, *Chairman,*
Edna Mabie,
Mr. and Mrs. Carl Slipper,
Mrs. L. T. Visovath,
John Jassi,
H. M. Hamilton,
Medical Society Committee of Parklawn.

The Medical Extension Committee of the Medical Society of Milwaukee County advised the committee at Parklawn that it would be impossible for it to make the plan available to a group representing so small a percentage of the population as was represented by those who had indicated their willingness to participate in the plan. The offer at Parklawn was, therefore, discontinued.

Industrial groups.—The plan as originally conceived was designed to be applied in part at least to industrial groups in the city of Milwaukee. Several attempts were made to find an industrial unit that would cooperate with the Society to subject the plan to further trial. The early solicitation efforts in industrial plants disclosed a factor that had not been anticipated by any of the framers of the plan or by our advisory committee. It was found that when representation was made to the proper officials at these plants, that some of these officials, after the presentation had been made to them, quite naturally resorted to the counsel of either a plant physician or a physician intimately associated with the plant in one of many other ways. It appears that in some instances the executives received no encouragement in their efforts. After this initial experience, solicitation of industrial plants was deferred for several months. Finally, however, the Medical Extension Committee formally requested that the executive personnel make direct solicitation efforts to a number of Milwaukee industrial plants. The following letter of solicitation was sent to Milwaukee industrial firms:

February 27, 1940.

_____
_____

Dear Mr. _____:

After completing a survey in the state of Wisconsin, a voluntary prepayment sickness care plan, developed by the State Medical Society of Wisconsin and this Society, was placed in operation in the Village of Greendale on November 1st, 1939.

The purpose of this plan is to provide the low income group with a means for financing medical care. The subscriber pays $1.00 per month per family, 75 cents per month for man and wife, or 50 cents per month for a single person. For this monthly payment the subscriber is eligible to receive medical care under the provisions of the plan, when

he has paid the physician of his choice $24.00 for medical services for himself or dependents in a given year.

Beginning on page 25 of the enclosed booklet entitled "Preliminary Report of the Advisory Committee on Voluntary Sickness Insurance," you will find the plan in its entirety. This plan is now available to employees in industry. Will you kindly write whether or not you think your employees would be interested in having this plan explained to them?

Cordially yours,

THE MEDICAL SOCIETY OF MILWAUKEE COUNTY,
DEXTER H. WITTE, M.D., *Chairman,*
The Medical Extension Committee.

The above letter was sent to the following industrial plants:

Allen Bradley Company
The Vilter Manufacturing Company
Outboard, Marine and Manufacturing Company
Monarch Manufacturing Company
A. J. Lindemann and Hoverson Company
The LeRoi Company
The Louis Allis Company
A. H. Weinbrenner Company
Joseph Schlitz Brewing Company
Pabst Brewing Company
Nordberg Manufacturing Company
Milwaukee Gas Light Company
Miller Brewing Company
Milcor Steel Company
George J. Meyer Manufacturing Company
Koering Company
Kearney and Trecker Corporation
Robert A. Johnston Company
Hummel and Downing Company
The Heil Company
Harnischfeger Corporation
Gridley Dairy Company
Harley Davidson Motor Company
Globe Union Company
Geuder, Paeschke and Frey Company
The Falk Corporation

In addition to the above, a special letter of invitation to participate was sent to the Federated Trades Council of Milwaukee. The invitation to the Federated Trades Council was as follows:

February 27, 1940.

Mr. Herman O. Seide, General Secretary
Federated Trades Council of Milwaukee
1012 North Third Street
Milwaukee, Wisconsin

Dear Mr. Seide: After completing a survey in the state of Wisconsin, a voluntary prepayment sickness care plan, developed by the State Medical Society of Wisconsin and this Society, was placed in operation in the Village of Greendale on November 1st, 1939.

The purpose of this plan is to provide the low income group with a means for financing medical care. The subscriber pays $1.00 per month per family, 75 cents per month for man and wife, or 50 cents per month for a single person. For this monthly payment, the subscriber is eligible to receive medical care under the provisions of the plan, when he has paid the physician of his choice $24.00 for medical services for himself or dependents in a given year.

Beginning on page twenty-five of the enclosed booklet, entitled "Preliminary Report of the Advisory Committee on Voluntary Sickness Insurance," you will find the plan in its entirety. This plan is now available for reference to your component labor organizations. If any of these organizations are interested, will you kindly have them contact this office and the plan will be explained to them.

Cordially yours,

THE MEDICAL SOCIETY OF MILWAUKEE COUNTY,
DEXTER H. WITTE, M.D., *Chairman,*
The Medical Extension Committee.

Shortly after receipt of this letter, the Federated Trades Council requested and received additional copies of the 1939 report of this committee. No further request or advice was received.

From among all of these contacts, not one industrial unit was obtained. A limited number of replies (approximately four) were received but indicated that they were not interested on the grounds that the employes were covered by standard insurance company group policies or mutual aid or benefit associations. Others indicated they would investigate or that they simply were not interested.

In addition to the above written invitations, personal solicitation and representation were made to the following:

The Milwaukee Journal
The Nunn–Bush Shoe Company
The Plankinton Packing Company
Pritzlaff Hardware Company*
The Huth James Shoe Company
Telephone Guild (Wisconsin Telephone Company)
Pittsburgh Plate Glass Company**

* All employes assembled for discussion.
** Employes circularized by company with folders furnished by Medical Society of Milwaukee County.

Unsuccessful efforts were made by the Medical Extension Committee to place the plan in operation in industrial plants.

Type of subscriber.—The only subscribers under the plan are those at Greendale. As stated in the report of this committee in 1939, one of the conditions upon which people may gain admittance to the village of Greendale is that they have an income in proportion to the size of their family.

Demands.—Contrary to expectation, there was, as in Douglas county, no immediate demand for medical care under this deductible type of insurance. During the first three months of service operation of the plan in Milwaukee county, the Medical Extension Committee had before it only one statement which met all qualifications and which was subject to payment. This statement amounted to $57, of which $24 had been paid by the patient, leaving a net statement for consideration of the Medical Extension Committee of $33. During the second quarter of operation, however, there was a material increase in the number of subscribers who were eligible for service under the plan. As of February 1, there were seven subscribers who were eligible for service by having paid their family physician the initial $24 and having kept their dues current. At the beginning of the third quarter (May 1), there were 21 subscribers (10 per cent) who had met all of the qualifications and who were eligible for benefits under the plan. On July 1, thirty-six, or 21 per cent of the 172 subscribers were eligible for services under the plan. The demands during the second quarter were quite extensive. By the end of the second quarter a total of an estimated $1,500 worth of service had been rendered to the twenty-one subscriber families who were eligible for service under the plan. After auditing the statements and deducting the initial $24 payments, there was a net amount due participating physicians of approximately $1,200.

There was no indication that there had been any nuisance demand made upon physicians for care.

As in Douglas county, there was no indication whatsoever that pregnant women consulted their physicians earlier under this plan than prior to its inauguration. Based upon data supplied by the subscribers themselves, it was found that in Milwaukee county physicians were consulted during the first two months of pregnancy by over 65 per cent of the subscribers. By the third month of pregnancy over 85 per cent had consulted their physicians.

Distribution of service demands among physicians.—Under this plan it is exceedingly difficult to draw any sound conclusions as to the distribution of service among physicians in Milwaukee county. Any conclusions that might be drawn would give a distorted picture due to the fact that two of the participating physicians were residents of the village of Greendale.

Physicians' claims.—Submission of statements to the Medical Society of Milwaukee County indicated that there existed a great confusion as to the conditions under which statements were to be submitted to the society. Considerable time and effort were required to review the statements in order that they all would conform to the plan itself and to the schedule adopted by the Medical Extension Committee.

Payments to physicians.—Eighty per cent of the subscriber income was earmarked for physicians' services. Based upon the statements received and the funds on hand for the payment of services rendered, it would have been possible at the end of the second quarter to have paid participating physicians 79 per cent of the minimum normal fees charged in Milwaukee for families in similar circumstances.

Statements being received for services during the third quarter would seem to indicate that a smaller percentage will be paid at the end of the trial period.

Administrative expense.—The income from subscribers' dues which was earmarked for administrative purposes was not sufficient to pay the administrative costs. Consequently your advisory committee authorized payment of this deficit by the State Medical Society. When the plan was placed in service operation the donation by the Medical Society of Milwaukee County of the time of its paid personnel was discontinued. A portion of the regular salary of the assistant executive secretary, Mr. Weber, was charged to the administrative account, as was all of the clerical assistance needed to conduct the plan.

Estimate of self-supporting premiums.—Because of the limited experience the committee does not feel warranted in making any conclusions at this time.

Committee Summary Comments, Milwaukee County.—1. Your committee feels that the deductible feature is basically sound and, from studies made both locally and in other states, it would appear to be a provision that should be included in this or some other manner in future experimentation to be conducted by the Society.

2. The arduous efforts of the citizens committees at both Greendale and Parklawn again demonstrated that there is very little uncultivated demand for voluntary sickness insurance. There was a similar lack of demand for a prepaid plan among the industrial groups which were approached for participation in the trial.

3. While in some instances cooperation was given by physicians intimately associated with industrial firms or plants in one way or another, in several instances it would appear that the plant executives received no encouragement from the physicians whose counsel was sought.

ROCK COUNTY

A plan to provide an unlimited amount of medical service to subscribers who, under the plan, maintained their regular monthly premiums of $3 per month per family, $2 for man and wife and $1.50 for a single person. Selection of subscribers was based upon the group theory. The subscriber was entitled to free choice of physician. This was a plan designed by the local medical profession and was to be administered by it.

Date of service operation of the plan.—This plan was not placed in actual service operation. It was offered to the public of Rock county on August 16, 1939.

Physician participation.—Over 75 per cent of the physicians in Rock county signified their willingness to participate in the panel established under the plan. There were but two or three members of the Rock County Medical Society who would have been available to subscribers under the plan who did not indicate their willingness to participate. There were some physicians who would not have been available to subscribers under the plan because of employment or retirement.

In one of the two main cities in which the plan was offered there was almost universal support and participation in the plan. In the other city, however, there was a division of opinion over the plan among the physicians. Some physicians were outspoken in their opposition to the plan both within medical circles and in their contacts with the lay public.

Method of selection.—Subscribers were to be selected under this plan on a group basis. Any group in Rock county that was organized for other than health purposes was eligible to participate provided 50 per cent of the group elected to join. The smallest group of service eligible subscribers was set at ten. No examination was required. This plan was offered to groups of all types and was designedly offered to those groups that could not be reached by the Milwaukee plan, which was conceived to embrace primarily large groups.

Solicitation.—The Medical Service Committee of Rock County, which was composed of fifteen members, formed the solicitation group for the Rock county plan. They were assisted in their efforts by

the assistant secretary of the State Medical Society. The Medical Service Committee of Rock County made a written offer of the plan to the following groups:

Janesville:

Rock Township Farm Bureau
Wisconsin Telephone Company
Carr's, Inc.
Scotch Presbyterian Church
Standard Oil Company
Rock County Welfare Department
Rock County Highway Department
County Employes
Janesville Fire Department
Janesville Police Department
Janesville Gazette

Beloit:

Beloit Daily News
J. J. Riordan
Beloit Telephone Office
Wisconsin Power and Light Company
McNeany Department Store
Federated Women's Clubs
Chester's Department Store
Beloit Public Schools
Beloit Vocational School
Business and Professional Women's Club

Personal solicitation and explanation of the plan was made by members of the Medical Service Committee and the assistant secretary of the State Medical Society to administrative officials of the following groups:

Janesville Police Department
Janesville Fire Department
County Clerk (Janesville)
Rock County Welfare Department
Wisconsin Telephone Company (Janesville)
Beloit Daily News
Wisconsin Telephone Company (Beloit)
Wisconsin Power and Light Company (Beloit)
McNeany Department Store (Beloit)
Federated Women's Clubs (Beloit)
Chester's Department Store (Beloit)
Beloit Public Schools
Beloit Vocational School
Beloit Business and Professional Women's Clubs
Freeman Shoe Company (Beloit)
Farm Bureau Federation (Janesville)
Janesville Gazette

The plan was offered to the members of the Federated Trades Council in Janesville on repeated occasions, but no interest was evidenced by them in the plan. Unsuccessful efforts were made to have an opportunity of discussing this plan with the officers of the Federated Trades Council in Janesville on January 24, February 5 and March 15, 1940, by written communication.

An invitation was extended to industrial plants both in Janesville and Beloit to send an employe representative to a dinner meeting at which the plan was explained in detail to the employe representatives, and the suggestion made that meetings be held in the several plants to enlist subscribers in the plan. Two meetings of this character were held in Janesville, and after some effort it was found that approximately 100 units indicated they would participate in the plan. One such meeting was held in Beloit. It was difficult to iron out to the satisfaction of those represented at the employe meeting in Beloit the settlement of border participation, having in mind the fact that the city of Beloit is located in Wisconsin and South Beloit is located in Illinois. Here one is confronted by different state statutes, state regulations by insurance commissioners, and similar conditions.

The following firms were invited to send employe representatives to the Janesville meeting. (Asterisk indicates attendance at one or both of the meetings held in Janesville.)

Frank H. Blodget, Inc.*
Hough Shade Company
Janesville Cotton Mills*
Janesville Shirt and Overall Company
Lewis Knitting Company
Northern Conveyor Company
Ossit Church Furniture Company
Rock River Cotton Company*
Rock River Woolen Mills*
Shurtleff Ice Cream Company
Bennison and Lane Bakery
Colvin Baking Company*
Wisconsin Power and Light Company
Cunningham Bakery
W. R. Arthur and Company*
J. M. Bostwick and Sons
Golden Eagle*
Sears, Roebuck and Company*
Carr's, Inc.
Swanson's Stores
Wisconsin Telephone Company
Gazette Printing Company*
City Ice Company
Teachers*
Nunn–Bush Shoe Company, Edgerton
Highway Trailer Company, Edgerton

The following firms were invited to send employe representatives to the Beloit meeting. (Asterisk indicates attendance at the meeting.)

Bean Shoe Company
Beloit Box Board Company
Beloit Concrete Stone Company*
Beloit Daily News*
Beloit Foundry Company*
Beloit Glove and Mitten Company
Beloit Hosiery Company*
C. H. Besley and Company*
Cunningham Brothers
Consumers' Company
Fish Oven and Equipment Company
Gardner Machine Company*
General Refrigeration Corporation
Hendley–Whittemore Company*
Illinois–Wisconsin Concrete Pipe and Tile Co.
Kanotor Bottling Company
Klenzade Products*
Lakeside Railway Fuse Company*
Lindahl Ice and Fuel Company*
P. F. Mork and Sons
Neilson Engineering Company
Simonds Worden White—Dowd Division*
Taylor Freezer Corporatoin
Warner Electric Brake Company*
Wisconsin Knife Works
Wisconsin Telephone Company*
Wisconsin Power and Light Company*

In addition to these formal written representations to specific groups and personal presentation to the employers and employes alike, presentation was made to the following employe groups or organizations, assembled specifically to have the plan discussed and explained to them:

Employes of Rock County Relief Department
Sears, Roebuck and Company employes
McNeany Department Store, Beloit
Business and Professional Women's Clubs
Council of Federated Women's Clubs
Janesville Police Department
Beloit teachers
Chester's Department Store, Beloit
Graduate Club of Beloit Vocational School
Newark Township meeting, Beloit
Young Homemakers' Club, Beloit
Pet Milk Company
Rotary Club, Janesville
Kiwanis Club, Janesville
Junior Association of Commerce, Janesville
Lions Club, Janesville
Janesville Pure Milk Company
Wadham's Oil Company
Janesville teachers

In addition to all of the above efforts of solicitation, pamphlets were distributed in pay envelopes of some employe groups and through physicians' offices

by their waiting room tables and enclosures in their monthly statements. A total of 5,000 pamphlets were distributed among the residents of Rock county in this way.

As a result of these solicitation efforts, there were ninety-one units which indicated their desire to participate in the plan. The groups which had made application and the number applying for subscriber membership were as follows:

Group name	Number in group applying
Janesville Pure Milk Company	10
Janesville Printing Company	7
Pet Milk Company	14
*Janesville teachers	27
Sears, Roebuck and Company, Janesville	22
Janesville Police Department	11

* There is an active teachers' association in Janesville which embraces in its membership over two hundred teachers. The president of this teachers' association was enthusiastic for a prepaid plan and attempted to interest the teachers in the Janesville area as a whole to participate in the plan. Of the two hundred-odd members of the association, there were only thirty to forty who indicated they might be interested in the plan. Consequently, the teachers' association, as a group, could not be considered. There was one school wherein the teachers were sufficiently interested to approach the 50 per cent participation which was required. It was necessary for this group, however, to interest a second school in order that the required 50 per cent minimum participation could be met.

The experience of the members of the Medical Service Committee in their efforts to solicit participation in the plan by groups is exemplified in a communication received from the director of the Rock County Relief Department, whose letter is quoted in its entirety below:

"I am sorry that I have not given you a report regarding the very fine talk that you and Dr. Munn gave this staff, but our committee was very slow to function and business has been very pressing.

"It was the consensus of opinion in this department that perhaps for those who are married and have children the plan might be feasible, but for just married couples or single people the amount that would be required under this plan would be more than they had spent, after figuring their medical expenditures, for the past several years. They also felt that it was not inclusive enough, as most of them seem to think that they could handle doctor bills but that hospital bills would work quite a hardship on them—or at least on the majority of them.

"As you probably noticed, we are all quite young in this department and are probably as healthy a group as you would find in almost any professional or business group. I might add that there is still quite a lot of interest in this department regarding a total medical plan, or, in other words, one that would cover both doctor and hospital.

"As I told you on your visit to this department, if at any time there is anything we can do for you in the way of statistics or other matters pertaining to medical aid, we will be glad to cooperate with you."

In discussing the plan with employers, the statement was made quite often that in spite of the fact that the physicians in Rock county were the actual reserves of the plan and could deliver the service promised to be given, the employers stated they would prefer to secure this type of insurance from a company that had established a financial reserve that could be seen on a balance sheet.

Type of subscriber.—The plan not having been placed in service operation, no conclusions can be drawn as to the type of subscriber interested in the plan.

Demands.—The plan not having been placed in actual service operation, no demands were made upon it.

Committee Summary Comments, Rock County.—1. This plan again demonstrates that there is an exceedingly small demand for voluntary sickness insurance based upon the features incorporated in the Rock county plan. The sales effort in Rock county was distinctly different from that which was exerted in either Douglas county or Milwaukee county. In Rock county the sales effort was primarily that of the physicians themselves. The criticism of this type of sales effort lies primarily in the fact that it is not closely organized, nor is it sustained. Yet here again, the reaction of those to whom sound and strong representation was made was one of indifference more than anything else.

2. A desire was found among those in the upper income brackets to provide themselves with an insurance of this character. The desire was more pronounced in Rock county than in Milwaukee county, although this factor did occur there also. Your committee cannot report on whether this was a real or fancied demand, nor can your committee indicate what the response of those in the upper income brackets would be if a proportionately higher premium were asked of them than of those in the lower income groups.

3. In the discussion of the feature of the plan providing for a maximum income limit as established by the Rock County Medical Society, the complaint was lodged, and the Medical Service Committee felt that creditable weight should be given to it in its deliberations, that the employes themselves would not like to be divided into income groups that would be known throughout the plant. That is, it would be embarrassing to the employes to have it known that they had this plan while others in the plant could not obtain it because their income was too high. The employers and employes alike felt the employes would smart under this distinction. The individuals in the so-called low income group were not interested in participation in the plan. Such interest as was evidenced was shown by those enjoying reasonably good incomes.

Section 5

SICKNESS INSURANCE BY STANDARD INSURANCE COMPANIES

For many years the established insurance companies engaged in the field of health and accident or casualty insurance studiously avoided writing sickness insurance coverage. Within the past few years, however, they have entered this field intensively.

A group of insurance companies were fully aware that they were embarking upon an uncharted insurance venture and agreed through what is termed by them a "conference" of those major companies that

are offering sickness insurance coverage that during the initial period of offering this insurance to the public, they would offer it at identically the same premium and to provide almost identical coverage. In this manner they will be able to pool all of their actuarial experience and be in a better position to establish reasonably sound premiums.

The primary reason for the entrance of the insurance companies into this field probably was an attempt to recoup a field of insurance that was originated by the hospitals,—namely group hospital insurance.

Within comparatively recent years insurance companies have offered to industrial employes life insurance, health and accident insurance, and similar coverages, on a group basis without regard to the individual risk within the group. That is, no physical examination was required of the individual for the life insurance offered. Past or probable future health of the *individual* was not considered in selling the group the insurance. The insurance companies, on their own volition, have required 75 per cent of the group to join before a policy is issued. In doing this they are assured of obtaining sufficient good risks to offset the bad risks in the group. The companies have in the past offered to employes on a group basis life insurance, accidental death and dismemberment insurance and weekly cash indemnity for absenteeism. This was followed by the addition of hospital insurance, and finally there have been added surgical benefits through the group policies in many industries.

Generally speaking, it has been the policy of the insurance companies to limit the coverage to employes only for both hospital and surgical benefits. There are exceptions to this policy and dependents as well as the employe are covered either for hospital care only, or hospital and surgical care.

One of the socially desirable features of group insurance is the fact that so far as the individual is concerned, it is noncancellable; that is, an insurance company cannot cancel out of a group an individual whose record discloses or by experience is found to be a bad risk. Regardless of the individual's experience, he can continue to obtain the coverage and the company cannot cancel his policy. If there is any cancellation whatsoever, it must be of the entire group. This is socially desirable in that the individual's insurance policy cannot be cancelled when he needs it most, that is, after a series of claims have arisen from sickness or disability.

Surgical benefit policies.—Surgical benefit policies written on a group basis have been limited to the employes, and only in rare instances are dependents given this coverage. Presumably surgical benefits were selected in the initial steps of the insurance companies for the reason that it is easy to determine the exact procedure performed. The second reason for selecting surgical coverage is that there are two sound deterrents for unnecessary demands; first, the loss of employment income and, second, the pain and fear of surgical procedures.

The premiums established and the benefits offered by the insurance companies which are members of the group conference are identical. The methods used in computing the premiums for hospital insurance are as follows:

Employe—15 cents per day per $1 of daily hospital benefit, for thirty-one days of coverage.

Dependents—45 cents per month per $1 of daily benefit, for thirty-one days of coverage.

The total cost for a family for $4 per day daily benefit for thirty-one days would be $2.40.

The premiums charged for surgical coverage are as follows:

Employe—Usually 35–40 cents per month per employe.

Dependents—$1.40 per month.

The premiums varied slightly when slightly different benefits were provided. The employe is provided with a schedule of fees showing the amount he will receive from the insurance company in the event he has the specified operation performed. The reimbursement to the subscriber for specified operations is the same for each of the insurance companies that belong to the group conference. Below is set forth an abbreviated schedule showing a few of the usual fees allowed.

Surgical Coverage

Schedule of Reimbursements to Subcribers

Appendectomy	$100
Breast amputation	100
Mastoidectomy: Single, $75; Double	100
Tonsillectomy	30
Fracture of: thigh, hip, knee, upper arm, etc.	50
Kidney, removal of	150
Obstetrical delivery	50
Thyroidectomy	150
Herniotomy: Single, $50; more than one	75

If the beneficiary has any of the covered surgical operations or procedures performed as an ambulatory patient, the reimbursement is only 50 per cent of the amount set forth in the schedule.*

Generally speaking, the maximum amount which the employe could receive for surgical benefits during the course of any one policy year was $150. That is, if an employe required an appendectomy during the early part of the year, and subsequently, a gastroenterostomy, his group insurance probably would provide him with $100 cash benefit for the appendectomy and subsequently would pay but $50 to the policyholder to apply on his second surgical operation.

Great flexibility is allowed, however, in writing policies to cover a specified industrial group. If the employes of a certain group appeared to be hesitant to pay 35 cents or 40 cents per month for the surgical benefits, a lower premium would be charged and a lower scale of benefits would be provided. That is, it is entirely possible in one community to have

* Insurance companies belonging to the "group conference" have eliminated this provision and reimburse the employe-subscriber for ambulatory service in exactly the same amount as for services performed in a hospital.

more than one schedule of reimbursement from the same company.

The surgical benefits payable to the employe are not necessarily conceived by the insurance companies as reimbursement to the surgeon for his services. However, the fact that such a schedule is in existence and the subscriber is reimbursed for a specified amount, in practice sets the fee in the mind of the policyholder-patient at that amount for which the insurance company agrees to indemnify him. In theory it is possible for the attending surgeon to charge $125 or $150 for a difficult appendectomy. In practice, however, it is difficult to obtain payment from the subscriber for any amount over the $100 reimbursement which has been set by the insurance company.

Dependent coverage.—There has been a tendency on the part of insurance companies to avoid issuing policies that will indemnify dependents for surgical procedures. The insurance company, when writing a policy to cover dependents, loses one of the major deterrents in making unnecessary demands, and that is absenteeism. In addition to this, of course the female risk is markedly greater than the male risk and a correspondingly higher premium is required. This higher premium makes the insurance unattractive to the employe.

Medical benefits.—None of the insurance companies belonging to the "group conference" has issued a policy which agrees to indemnify the subscriber for *medical* costs such as home and office care and hospitalized medical care. The insurance companies recognize that it is exceedingly difficult to administer a policy of this kind. There are not the deterrents to home and office treatment that there are in hospitalized cases.

Cost.—Coverage written by members of the group conference providing thirty-one days of hospitalization at $4 per day and an additional allowance of $20 for such medical services as radiologic services, anesthesia, and pathologic services, plus a maximum of $150 of surgical benefits, would cost the employe, $1 per month. To give each of his dependents a similar coverage would cost the employe $3.20 additional, or a total of $4.20 to cover the family.

Extent of coverage.—The Wisconsin Statutes provide that the minimum number that may be written under a group policy is twenty-five. Members of the group conference have adhered to the policy of not writing groups of less than fifty. Under these conditions it should be recognized that only a limited section of our population can be covered by this type of insurance, as there are a large number of employers who have a payroll of less than fifty individuals, and there are, of course, many independent contractors, farmers, domestic servants, etc. It is estimated that about 12 per cent of Wisconsin citizens would be covered even if *all* of the industries in the state employing fifty or more elected to have this type of coverage. If *all* of the employe groups of fifty or more and *all* of their dependents were covered it is estimated that 24½ per cent of the people in Wisconsin would be covered. If the insurance companies did not liberalize their policies so as to include smaller groups, there would still remain 88 per cent of Wisconsin citizens uncovered.

Importance to profession.—We attempted to arrange a conference of the members of this committee and representatives of the American Mutual Alliance and the Association of Casualty and Surety Executives to discuss the many problems associated with the offering of sickness insurance by these companies. The wish of the committee to have such a conference was not possible of fulfilment as the Association of Casualty and Surety Executives declined to participate. The Association of Casualty and Surety Executives represents a voluntary association of the stock insurance companies in the United States, and the American Mutual Alliance represents a voluntary association of the mutual insurance companies in the United States.

The entry of insurance companies into the field of hospital insurance and sickness insurance is important to physicians individually and collectively in that it may have a direct bearing on the future planning of both. It is further important both to the physician and the patient that they know precisely what is and is not covered. It is further important to the physician in that this may have a tendency to "freeze" the reimbursement to physicians at a fixed amount regardless of the ability of the individual patient to pay.

Recommendations.—We recognize that the problem presented by the entry of insurance companies into the field of surgical coverage, and perhaps in the future, to medical coverage, is more than statewide in its application. We do feel, however, that it is of such import as to warrant constant study by the Society as to its application in Wisconsin. The problem, however, is of national scope and this national problem should come under the jurisdiction of our parent organization, the American Medical Association. To this end your committee recommends: **That this House of Delegates express to the officers of the American Medical Association its deep concern over the activities on the part of commercial insurance companies in the field of prepaid sickness care, and that this House of Delegates urge that further efforts be exercised by the proper officials of the American Medical Association to establish close relationships with those insurance companies offering prepaid sickness care to the end that all parties affected by such insurance may receive the utmost consideration.**

The Advisory Committee on Voluntary Sickness Insurance will make definite recommendations on voluntary sickness insurance to the House of Delegates when the House convenes at the annual meeting of the Society in Milwaukee. These recommendations will be published in a later issue of The Journal.

MEMBERS—1940 HOUSE OF DELEGATES

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Brown–Kewaunee–Door	P. R. Minahan, Green Bay	W. W. Kelly, Green Bay
	O. A. Stiennon, Green Bay	W. E. Leaper, Green Bay
Calumet	F. P. Knauf, Kiel	J. W. Goggins, Chilton
Chippewa	C. N. B. Hatleberg, Chippewa Falls	A. J. Somers, Chippewa Falls
Clark	(To be reported)	B. H. Dike, Owen
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Kenosha	G. C. Schulte, Kenosha	W. C. Stewart, Kenosha
La Crosse	A. H. Gundersen, La Crosse	E. E. Gallagher, La Crosse
Lafayette	(Not reported)	
Langlade	W. P. Curran, Antigo	(Not reported)
Lincoln	F. C. Lane, Merrill	R. G. Baker, Tomahawk
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	R. E. Galasinski, Milwaukee	G. S. Flaherty, South Milwaukee
	J. L. Garvey, Milwaukee	P. J. Niland, Milwaukee
	L. W. Hipke, Milwaukee	P. E. Oberbreckling, Milwaukee
	Irwin Schulz, Milwaukee	(To be reported)
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	A. R. Langjahr, Milwaukee	Bernard Krueger, Cudahy
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Rock	W. A. Munn, Janesville	W. T. Clark, Janesville
	H. E. Kasten, Beloit	H. A. Raube, Beloit
Rusk	L. M. Lundmark, Ladysmith	W. F. O'Connor, Ladysmith
Sauk	A. C. Edwards, Baraboo	M. F. Huth, Baraboo
Shawano	A. A. Cantwell, Shawano	F. L. Litzen, Gresham
Sheboygan	C. J. Weber, Sheboygan	A. C. Radloff, Plymouth
Trempealeau–Jackson–Buffalo	R. L. Alvarez, Galesville	M. O. Bachhuber, Alma
Vernon	W. M. Trowbridge, Viroqua	W. H. Remer, Chaseburg
Walworth	E. D. Sorenson, Elkhorn	C. J. Brady, Lake Geneva
Washington–Ozaukee	J. G. Hoffmann, Hartford	O. J. Hurth, Cedarburg
Waukesha	J. C. Hassall, Oconomowoc	R. E. Davies, Waukesha
Waupaca	J. H. Murphy, Clintonville	R. K. Irvine, Manawa
Winnebago	A. G. Koehler, Oshkosh	J. P. Canavan, Neenah
Wood	K. H. Doege, Marshfield	F. X. Pomainville, Wis. Rapids

Health and Medical Preparedness*

By THOMAS PARRAN
Surgeon General, U. S. Public Health Service

THE problem which concerns each of us today is what we can do to contribute to the safety of our country. Traditionally, as doctors and nurses, we have been servants of peace. When war did come, it was our job to patch up the wounds, ease the suffering of the wounded, and repair as best we could the damage done by shot and shell.

We are not at war. If we have time enough—if we are swift and wise enough in the time that we have—war in this hemisphere may be prevented. But the old rules of war, and the preparation for it, have been demolished. The whole task of national defense is different than it was 25 years ago. Just as the perversion of the physical and chemical sciences has brought more brutal, more rapid, more devastating destruction both to unprepared armies and unarmed civilians, the developments of the medical sciences have expanded the scope of what doctors and public health workers can do for preparedness. The concept of a total war necessitates the concept of a total defense—a total national effort, not only toward resistance but toward unassailable strength.

Psychologically, this country as yet seems unprepared for the total effort toward strength which recent world events make imperative. On the one hand we hear imprecations because we are not now better prepared in guns and ships and planes and organized manpower. On the other hand, we hear criticism at steps taken now to prepare promptly against aggression toward ourselves, or our immediate neighbors. One of the risks I see to national unity of action lies in the idea that defensiveness, alone, is all we need to preserve our democracy. Yet, as Governor Lehman has said again and again, democracy is a thing we must constantly fight for. All recorded history shows, I think you will agree, that no nation has arisen to strength, as we have, or remained strong, as we hope to,—no human rights have been established or liberties maintained—without dynamic, aggressive action. St. Paul and the apostles were not defensive when they established the Christian faith. Our Revolutionary ancestors were not defensive when they fought to establish human liberties and found a nation. The Boston Tea Party, for example, was one of the most provocative acts on record. Buchanan was merely defensive when he permitted the Nation to fall into the turbulence and dissension which preceded the Civil War. Lincoln took the dynamic aggressive to preserve the Union, without which we now should be as helpless as little Denmark.

Today I would discuss with you the aggressive action which you and I, by virtue of our calling—because we are the servants of peace—must take to build up national strength. The needs to be met are enormous in scope, yet simple in analysis. National strength can be built up only by the adequate application of all the sciences to the provision of armament, munitions and supplies, food, and manpower. Our job is manpower.

Seven competent, trustworthy persons recently were called to assist the Government in national defense. Industry is represented, both in raw materials and processing. Labor, agriculture, transportation, the consumer, are represented. There is a shrewd eye on the stabilization of prices. Research problems in the physical and chemical sciences are being attacked with vigor by an able committee, which will apply all the knowledge we have or can discover to the perfection of armaments. Yet, so far as I know, there has been no more thought than in 1917 of the application of medical and public health science to the physical problems of a nation arming.

Yet for what cause is this Nation arming if not on behalf of the men, women, and children who compose it? Their physical fit-

* Read before New York State Conference of Health Officers and Public Health Nurses, Saratoga Springs, June 25, 1940.

ness, their freedom from preventable disease, their morale or mental stamina, will determine almost entirely the effectiveness of all other defense efforts. Important in the easy days of peace without a cloud on the horizon, it is urgent now that the people of this Nation be physically tough, mentally sound, and morally strong. If we are not, to quote Mr. MacLeish, "we can leave our planes unbuilt and our battleships on paper. We shall not need them."

In time of stress, the health problems of the military and civilian population are inseparable. At present they are the responsibility of many unrelated Federal agencies having the happiest personal good will toward one another, but with no more official authority or compulsion toward coordinated action than did an airplane factory and an automobile plant 2 months ago. Each of these agencies legally can perform only certain functions set up by law. None of them has a close, working integration with the organized medical and public health professions. The State health departments are as diverse as the 48 States. None of the official agencies have the benefits of a full working relationship with the great voluntary associations for health and welfare, in which doctors, dentists, nurses, engineers, in their technical capacity, work side by side with citizens to caulk up the leaks in the hull of our national manpower. None of the official agencies has the full aid and service which the public spirited foundations set up to promote health and welfare are able to give.

Our defense plans, for the immediate emergency, are still young. There is much in the way of organization and coordination yet to come. But as a first step in meeting the vital needs of manpower preparedness, I propose that a coordinator of medical and health preparedness for national defense be appointed under the National Defense Council. There is much for him to do. He would work with and through the Surgeons General of the U. S. Army, the U. S. Navy, and the U. S. Public Health Service, other Federal agencies, and the national voluntary organizations concerned with the prevention, diagnosis, and treatment of disease.

A first task is the need for listing and classifying professional and technical personnel in the country; for planning and aiding, if and when necessary, the recruitment and mobilization of medical and health personnel.

Another urgent task involves the protection and promotion of the health of industrial workers. With the vast expansion of the war industries, many new industrial hazards appear and familiar ones are intensified. When new factories are designed, expert industrial-hygiene advice is required for proper installation of power exhausts of chemical gases. Records of present performance show the need of extended industrial-hygiene measures to control and prevent special health hazards. In the recruitment and training of workers, thorough physical examinations are necessary upon employment and periodically thereafter. It is wasteful for industry to train a highly skilled employee over long months, only to have him break down suddenly with tuberculosis, mental disease, or some other crippling condition. The expansion of war industries will bring acute problems of housing, medical care, and health protection for workers and their families. Our industrial machines are the most efficient in the world. The men and women who man the machines must have a comparable efficiency.

Certain diseases have particular military importance. The venereal diseases are at the top of the list. They caused more disability in the last war than anything except wounds and influenza. Fortunately we have been forehanded in building some machinery in every State to deal with this problem. We need to intensify these efforts, especially in those areas of military and industrial mobilization.

The importance of tuberculosis is accentuated by the current situation. Here, too, we have made some progress since the last war in terms of a lower active infection rate and a lower death rate, but we do not have in any State the machinery to detect all active cases of the disease. In very few States do we have the sanatoria to care for such cases. It should be possible promptly to find and to isolate all sources of infection. Recent devel-

opments in the small and microfilm techniques mean that we can easily afford it.

Not one of the seven fine persons on the National Advisory Commission of the Defense Council, however, is aware of what this country can do to eliminate tuberculosis as a major obstacle to national security. We know that Hitler has put all of his active tuberculous together in factories to give—between dying coughs—a few months of service in munition making. This was segregation and service to the state but without regard for the welfare of the individual. If we plan well now, we shall not need such suicide squads for bomb manufacture. Segregate, yes. But let us restore also.

Of the many military medical and health problems in the tropical Americas, the most important is malaria. There is no disease of comparable importance (except the mental diseases) against which we have made less scientific progress, during my generation. Quinine is still the major remedy. Like rubber, originally secured from South America, now our major source of supply is from across the Pacific Ocean—the Dutch East Indies. Holland is no longer able to import, process, and distribute this remedy. Its cartel prevented us from storing a sufficient war chest of our most needed medical strategic material. All of Central and South America now look to us to supply their needs. For 2 years I have been concerned with this problem. It is not yet solved. No major military operations in the tropics of this hemisphere are possible without quinine or the equally potent German synthetic—atabrine. Here is another job for a National Coordinator on the medical front.

Another strategic medical material, for which we are dependent upon foreign sources, is opium. For 4 years I have prescribed the total annual amounts which could be imported into the United States. Before and after Munich, I aided our commercial importers to build up a war chest of opium and morphine. In the vaults at Washington, formerly used to store gold, we have stored enough morphine for at least 3 years. Our regular source has been from the Eastern Mediterranean, now closed. Before this supply is exhausted, we can if necessary grow in certain areas of the United States the pain-relieving poppy plant. But it must be planned now.

Other diseases require our attention. Next to the venereal diseases, mumps is the most disabling of the acute infections among recruits. Meningitis was a great hazard during the last war. Influenza still is a major threat. During the intervening 22 years, many facts about it are becoming clear, but with present knowledge, effective prevention and control is not possible. Research must be speeded up and coordinated. It may be that the nation which first learns how to control influenza will by this knowledge tip the scales toward victory in the wars ahead. No one now is coordinating our search for the practical prevention of this major hazard to successful defense. Until recent months we could expect aid from medical discoveries in our sister democracies. Now in this country, alone, we must carry the burden. As yet we have not gone forward with it.

When armies are mobilized certain proven immunizations are used. Typhoid fever, yes. Smallpox, yes—since Jenner's discovery of more than 100 years ago. A recently developed toxoid against tetanus is of proven value and will be used routinely. Effective immunization against gas gangrene would be another great aid. By a few months of coordinated effort on the part of commercial, university, and governmental groups, a practical protection against this major war hazard should be perfected. Here is another job for the Coordinator.

Our first concern may be in tropical America. I have discussed malaria. What about yellow fever? Prevalent throughout large areas of South America, a constant threat to the southern half of the United States, we do not have in this country enough of the effective vaccine against it to immunize one regiment! In spite of the requests from year to year, I have not been able to secure funds with which to produce a reserve supply.

These examples, among many I could cite, illustrate my major thesis. There are many diseases, of great military importance, which we could control if we were given the will, the authority, and the money to do it.

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If or when war comes, every 1,000,000 men mobilized need 7,500 doctors drawn from civil practice. Dentists, nurses, sanitary engineers are needed too. In the mobilization of 4 million during the last war, more than a fourth of the effective medical men of the country were called to the colors. Whole counties were depleted of doctors. Many medical schools were almost put out of business, because the best men left for military duty. We should not repeat these mistakes. Today we should investigate who should go, who should stay to practice, to teach, to operate an essential civilian service. We have no machinery now to do this. A Coordinator of medical and health preparedness should create the machinery, working with the public health agencies, the schools, and the medical profession itself.

We have a shortage of laboratory technicians. Intensive courses would provide more. Universal training would deplete the ranks of medical students; yet we need doctors each year to replace obsolescence. Some medical and other scientists are vastly more valuable to the country working on their present jobs than they possibly could be in the Army or Navy. Here are other tasks for medical planning through a Coordinator.

Further, let us consider the whole problem of national fitness. The President has recommended that all youth give 1 year to public service—be trained during this time in some skill. How fit are they from a physical and mental viewpoint? Enrollment should include a careful examination. All correctable defects should receive prompt attention. As yet, there is no organization, no planning of an organization to do it. This is a task projected.

Let us consider two tasks immediately before us. The National Youth Administration employs 300,000 young people. Here is a measurable group, beneficiaries of the Government. After 5 years no plan has been worked out to appraise their physical status. Shouldn't we take this group of underprivileged youth and apply our proven medical science to relieve their correctable defects?

Employed by the Work Projects Administration are nearly 2 million people. The Nation wants to use their services; they themselves want to serve in the ways they can best contribute to national safety. What is their physical status? No one knows. I propose that each of them be examined; that we use methods comparable to those of the Draft Boards of 22 years ago, and classify the Work Projects Administration employees physically into three or four classes. Those qualified to become good workmen should be first on the list for training in the industries now short-handed. Those who have remediable defects merit rehabilitation. Up to now no agency has had the authority or the money to do these two specific jobs which seem important in national preparedness.

If our workers are malnourished, they cannot be efficient in producing what we need for defense. Yet every survey of nutrition, by whatever method conducted, shows that malnutrition in this country is widespread and serious. For example, studies by the Department of Agriculture show that 40 per cent of the people are not getting a diet adequate to maintain good health and vigor. Eight out of every ten in this category do not have an income sufficient to purchase, at market prices, a diet adequate in amount and kind; this in spite of the fact that the foods of which the Nation has an apparent surplus are those in which the dietary of so many is deficient—milk and milk products, citrus fruits, green vegetables, and meat.

Not through any pity for their working people, but because their scientists proved to them that it was an essential to national power, the Germans began several years ago to provide for the working masses a diet better than ours have now. We have made a beginning in this direction through the food-stamp plan. What we need is an intensive national drive, with rigid scientific controls, to use the food we have to improve the fitness of our manpower.

Though I would not presume to draw up a blueprint for the whole effort of health preparedness, each of the problems mentioned needs prompt attention. With authority from the National Defense Council, several committees of experts, both official and professional, should undertake special responsibilities. What seems now a huge, illimitable job is, in reality, a composite of measurable

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tasks. There is a competent person to do each, if it is assigned to him. There is the will among our professions and among our citizens which will see that each is done. But I repeat, the first step is a strong leader in the National Defense Council to see that the country's needs are met for physical and mental preparedness, for health and medical mobilization, for peace or war. At the same time he would serve to unite the efforts of official, professional, commercial, and voluntary groups in our unified drive for aggressive strength.

In the past there has been division of opinion and occasional dissension among our professions concerning methods proposed to bring better health and a higher standard of medical care to our people. In the face of danger it is the democratic way—even the herd instinct—to unite for the agreed objectives of safety. We cannot now afford controversies. The preparedness of our manpower for national safety is not controversial. Given a hand in the planning, all of us together, official and professional, can work out methods in which we all believe.

There is no time for dogged adherence to outworn patterns, nor for a major change in proved forms of medical practice. Medical science grows, expands, opens up new possibilities for saving life and building strength. In the application of its basic sciences, medical practice must expand also to meet the new demands of the Nation for self-preservation.

In the dictatorships, the state is served by sacrifice of the individual and enslavement of the men of science. If our democracy is to stand, we—as doctors, as health officers, as health workers, as citizens—of our own free will because we know it is necessary, must put medical science to work now, fully, to make our men as good as our machines.

The Journal Bookshelf

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Introduction to Medicine. By Don C. Sutton, M.S., M.D., associate professor of medicine, Northwestern University School of Medicine; attending physician, Medical Division of the Cook County Hospital; chief of the Cardiac Clinic, Cook County Hospital, Chicago; attending physician, Evanston Hospital. With an introduction by Ada Belle McCleery, R.N., superintendent, Evanston Hospital, Evanston, Ill. Cloth. Price, $3.25. Pp. 642, with 144 text illustrations and 14 color plates. St. Louis: The C. V. Mosby Company, 1940.

The title as stated above, "Introduction to Medicine," should be amplified to include the subtitle "For Schools of Nursing." The book is well organized and contains a generous number of adequately good illustrations. The major portion is devoted to a description of disease entities, including those required by the Committee on Curriculum of the National League on Nursing Education. The discussion of treatment very properly stresses the nurse's relation to the appropriate care in each case. Although the reviewer is not particularly familiar with the field of medical textbooks for schools of nursing, this one seems generally commendable. M. L. C.

The Poison Trail. By William F. Boos, M.D. Cloth. Price, $3. Boston: Hale, Cushman & Flint, 1939.

The publishers send out this book with a rather lurid cover jacket, to emphasize its title, but the book itself (as well as its binding) is thoroughly respectable. It is an interesting combination of light and informative reading, dealing with problems that confront the toxicologist. The manner of its writing is simple, and pleasingly free of synthetic breathlessness. To the lay reader, for whom it is of course intended, it will probably appeal both by the tang of "true" murder tales—sometimes mysterious—which illustrate it throughout, and also by scientific authenticity that justifies and rewards such reading.

The writer is obviously fascinated with the many-sided aspects of the profession which picked him out when he was still a boy. These not only satisfy a craving for scientific sleuthing, but also point ways for the betterment of public health by education in the control of noxious agents, both in industry and the home. On the other hand, the soundly-trained "poison specialist" can debunk some exaggerated fears—such as that of ptomaine poisoning, and of botulism from canned foods—which persist unreasonably even in the minds of some medical men.

A book of this kind can doubtless further such causes by dispensing sound information, especially when it is written in such a way that people will read it. (That they will and do is suggested to this

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Dr. Alvarez mentions a few of the beliefs and superstitions which too many even intelligent people find a part of their credo, and then traces the simple and peculiar origins. Dr. Larkey scouts out data on the health conditions and care in the English fifteen-hundreds. Dr. Drinker recalls how near is the time of his great-great-grandmother, who had the habit of noting down the health of her family. Dr. Heyd tells of dramatic changes which have made surgical progress of dramatic interest. Dr. Hoskins briefly traces insanity from demonology through the days of horror to reform. Dr. Menninger slyly describes the loose relationship between psychiatry and its practitioners and the other fields of medicine.

The volume is aimed at the laity. It could well be given as a present by a physician to his patient, or vice versa. The best fate for this book would be to fall into the hands of an Elizabethan-like public, which read medical books as much as it pleased and sometimes even wrote them. W. H. O., Jr.

Diabetes: Practical Suggestions for Doctor and Patient. By Edward L. Bortz, A.B., M.D., F.A.C.P., associate professor of medicine, Graduate School of Medicine, University of Pennsylvania; chief of medical service B, The Lankenau Hospital, Philadelphia; assistant editor, The Cyclopedia of Medicine. With a foreword by George Morris Piersol, B.S., M.D., F.A.C.P., professor of medicine, Graduate School of Medicine, University of Pennsylvania; editor in chief, The Cyclopedia of Medicine. Ed. 2, revised and enlarged. Cloth. Price, $2.50. Pp. 296, illustrated. Philadelphia: F. A. Davis Company, 1940.

This volume of 296 pages contains a great many bits of information about diabetes of interest to patients and physicians. The language is chosen largely for the sake of intelligent patients, but not infrequently is in such terms as would be understood only by a technically trained reader. In many cases, the attempted explanations go beyond the capacity or interests of the diabetic patient to understand. In spite of the rather large amount of material in the book, the details about preparing diet so as to secure variety, and to meet emergencies, are rather scanty. E. L. S.

Psychiatry for Nurses. By Louis J. Karnosh, B.S., Sc.D., M.D., associate clinical professor of nervous diseases, School of Medicine, Western Reserve University; director of neuropsychiatry, City Hospital, Cleveland; consulting neuropsychiatrist, Cleveland Clinic. In collaboration with Edith B. Gage, R.N., supervisor, neuropsychiatric division, City Hospital, Cleveland. Cloth. Price, $2.75. Pp. 327, illustrated. St. Louis: The C. V. Mosby Company, 1940.

This text on psychiatry follows the same general pattern which most books published within the last few years have presented. The first chapter gives an historical review of psychiatry after which considerable space is given to the psychobiology of mental illnesses. A classification of mental diseases by Meyer is included. Each entity is then considered under a separate heading or chapter. Prominence is given to the mental ailments in direct proportion to their frequency and to the theory and the nursing care involved. The special therapies which include occupational and recreational therapy, physical therapy and shock therapy and both insulin and metrazol therapy receive adequate consideration. The book concludes with some legal aspects of mental disease and with a chapter on mental hygiene.

An instructor in psychiatric nursing may feel that not enough space or attention has been given to the nursing care of patients. Also, psychotherapy as such is not stressed. Many feel that the informal psychotherapy which takes place whenever one has occasion to contact the patient is exceedingly important. Only a few references to this are made. But, on the whole, this book, written in a simple direct style and not over-burdened with too many new and difficult terms, is a good text for the nurse who is beginning the subject of psychiatry. The bibliography and the questions at the end of each chapter should prove to be very valuable to the student and to the person who is teaching the course. The illustrations and the case histories incorporated to enlighten the theory are excellent. Because it is practical and up to date, it should prove a very desirable book for use in nursing schools. E. A. S.

Chemotherapy and Serum Therapy of Pneumonia. By Frederick T. Lord, M.D., clinical professor of medicine, emeritus, Harvard Medical School; member of the Board of Consultation, Massachusetts General Hospital; Elliott S. Robinson, M.D., Ph.D., director, division of biologic laboratories, Massachusetts Department of Public Health; Roderick Heffron, M.D., medical associate, The Commonwealth Fund and formerly field director, Pneumonia Study and Service, Massachusetts Department of Public Health. Cloth. Price, $1. Pp. 174. New York: The Commonwealth Fund, 1940.

This is a practical and worth-while book of use to the general practitioner, and specialist. There is a thorough discussion of methods, indications, contraindications and statistical results. It is more terse and compact than other publications about the same subject. C. F. M.

Graduate Medical Education: Report of the Commission on Graduate Medical Education, 1940. Cloth. Pp. 304. Chicago: University of Chicago Press, 1940.

Important developments in the hospital internship, the hospital residency and the postgraduate educational opportunities for physicians in practice were suggested by the Commission on Graduate Medical Education, whose final report was published on June 25. The Commission, which was organized by the Advisory Board for Medical Specialties on December 4, 1937, is now bringing to a close its three year study program. Its work has been financed by national foundations and interested professional organizations.

The internship, suggests the Commission, should be considered as a basic preparation for the practice of medicine. It should round out and give practical application to the medical school course and, hence, should be closely allied to undergraduate medical education. It should prepare young physicians adequately to begin general family practice and should provide them with the essential preparation neces-

sary to undertake further study leading to the practice of a specialty. It should not attempt to train men for the specialties directly and, therefore, the intern should not be given training in the detailed technics of the specialties.

To prepare the intern for general practice, he should have experience in internal medicine, pediatrics, obstetrics and gynecology, and surgical diagnosis, minor surgery and treatment of emergencies. Special attention in these fields should be given to preventive medicine and the care of chronic diseases, conditions of the aged and functional disturbances. The whole atmosphere should be educational in character and the intern should learn by example as well as precept.

The residency is defined by the Commission as a prolonged period of study in one of the special fields which can be properly classed as graduate education, whether an advanced degree is granted or not. The Commission warmly supports the recommendation of the specialty boards that adequate attention be given during the residency to the basic sciences as they relate to the various specialties. It suggests practical ways by which hospitals may provide this basic science training in their own laboratories or through arrangements with medical schools. The report suggests that there is danger that too many residencies may be developed and stresses that, in the best interests of the patient, high quality of teaching in the residency is now more important than a large increase in the number of residencies. The essentials of a satisfactory residency are listed in some detail, although the Commission takes pains to point out that it does not wish to standardize residencies or put them in a strait-jacket.

Postgraduate education the Commission defines as study intended to keep a physician abreast of his chosen field of practice but not intended to equip him to enter a new field. Separate and clearly defined types of work are recommended for general practitioners and for specialists. While there has been a marked and rapid increase in interest in the field of postgraduate medical education, there is still need for its further extension and for improvement in the type of opportunities offered. The report points out the advantages and disadvantages of the various types of training now provided.

The effect of the work of the specialty boards upon the practice of medicine is discussed in the report, which points out that these boards have provided a well defined yardstick for measuring an individual physician's competence in his specialty. Men in the specialties have been certified so rapidly that it soon will be possible for the great majority of the people of this country to have access to the services of certified specialists.

The entire report stresses the value of adequate training and points out that this will be reflected in improved care of patients.

Manual of Graduate Training in Surgery. By the Committee on Graduate Training in Surgery, American College of Surgeons. Paper. Pp. 24. Chicago, 1940.

Pursuant to its aim of raising the standards of surgery, the American College of Surgeons has published a 24-page "Manual of Graduate Training in Surgery" in which are incorporated the requirements for its approval of programs of training in general surgery and the surgical specialties in hospitals of the United States and Canada.

The "Manual" is the outcome of ten years of study of educational programs in surgery by the Board of Regents and several committees of the College. In 1937 a Committee on Graduate Training in Surgery was established under whose direction the field staff of the College personally surveyed a selected group of hospitals in connection with the work of the Hospital Standardization Department. Based on the findings of these surveys, "Fundamental Principles and Criteria" were developed which have been applied in evaluation of plans for graduate training in surgery. The plans of 179 hospitals have so far been approved by the College. The new "Manual" is an elaboration of the "Fundamental Principles and Criteria" and will in the future be applied in determining eligibility for the Approved List to be published in the Approval Number of the College Bulletin in October of each year.

Medicine and the State. The Relation between the Private and Office Practice of Medicine with Special Reference to Public Health. By Sir Arthur Newsholme, K.C.B., M.D., F.R.C.P. With a foreword by William H. Welch, M.D., LL.D. Cloth. Pp. 300. Baltimore: Williams and Wilkins Company, 1940.

This is the second edition of a book originally published in 1932 as the final volume of four of the International Studies. The first three volumes deal more specifically with the relation between the private and official practice of medicine with special reference to public health in the leading countries of Europe. The fourth volume draws conclusions from the facts presented in the first three volumes.

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This study which extended over a considerable period was financed by the Milbank Memorial Fund of New York.

Sir Arthur Newsholme has a rich background of training for this study. At one time he was Medical Officer of Health of Brighton, England, and later was the physician chosen by Johns Hopkins University to develop their School of Hygiene and Public Health. In the introduction Sir Arthur says, "I am solely responsible for the contents of the present volume. Many opinions are stated in it which are essentially controversial; and although they are based on the experience of a long professional life, I fully realize the perplexing and sometimes conflicting factors which appear and impel observers to opposing conclusions." His observations and conclusions are most interesting and thought provoking. R. C. B.

The Era Key to the USP XI & NF VI. Ed. 5. Revised by Lyman D. Fonda, professor of pharmacy, Brooklyn College of Pharmacy, Long Island University. Cloth. Price, $1. Pp. 320. Newark, N. J.: The Haynes & George Co., Inc., 1940.

The Era Key to USP and NF should serve an occasional useful role for quick reference to established drugs. However, like any epitome on drugs, it gives no clues as to choice of drugs or how to use them; consequently, it should be assumed that the clinician already knows what he wants to use and why. The Key might on occasion give clues as to the identity of drugs for which unusual names are being employed. A. L. T.

Fractures. By Paul B. Magnuson, M.D., F.A.C.S. Ed. 3. Cloth. Price, $5. Pp. 511 with 317 illustrations. Philadelphia: J. B. Lippincott Company, 1940.

Dr. Magnuson's book on fractures presents to us those methods which he has personally tried. This in itself makes the book of value since his experience in the treatment of fractures has been large. The methods he has used are in no way original but they have been successful. It is interesting to note that most of his procedures are simple and they follow the fundamental principles in the treatment of fractures.

Complicated procedures and operative procedures he has left for the specialist and because of this, this book is especially satisfactory for the man who treats the fracture first.

The first four chapters of the book, as in the original, are devoted to fundamentals and equipment. The various fractures are discussed regionally. Chapters 27 and 28 contain a discussion of the simple physiotherapy procedures which are of value in the rehabilitation of the injured member.

In comparison with his previous book the bibliography is improved and the articles are brought up to date. The section on fractures of the neck of the femur has been rewritten and new illustrations have been inserted.

The book, I believe, accomplishes its object. It is written for the man who first treats the fracture and gives sufficient information to him so that he may treat his fractures better and improve his end results. H. W. W.

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*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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HARPER—RETROPOSITION OF UTERUS

(Continued from page 610)

that it is very rash to advise a woman that she cannot conceive unless one has personally removed the uterus—even then be cautious. I feel that retroversion is seldom a proven cause of sterility, although I must confess that I usually try to replace the uterus and insert a pessary for several months in order to eliminate the posterior position as a factor, and sometimes secure a prompt and favorable result. Most women with retroversion of the uterus conceive in spite of it.

Pregnancy proceeds normally in the vast majority of retroposed uteri unless they are adherent. There is a rather general feeling that abortion is more common in the woman with retroversion and, although this is difficult to prove, the anterior position seems to me preferable. The anterior position is encouraged by the use of the knee-chest position thrice daily. If the uterus fails to rise by the third month, I suggest gentle effort at replacement. If symptoms of pressure arise, I urge replacement. One uterus, replaced after the onset of slight bleeding at the third month, went normally to term. As abortion may follow manipulation of the uterus, as a result or as a coincidence, the patient should be warned beforehand. If the pregnant uterus be adherent in the sacral hollow, continued pressure on the bowel and bladder may become serious and surgical replacement be required. Abortion should not be performed for the retroverted pregnant uterus.

I have never seen pernicious vomiting relieved by replacement of a retroverted pregnant uterus, although I have tried to relieve it in this way several times.

Defective muscular function is difficult to evaluate, but I have not observed that labor is prolonged by early retroversion of the uterus. Rarely, the thickened posterior wall of an adherent pregnant uterus that has gone to term may obstruct the pelvis and require section for delivery.

The first two or three puerperal weeks are not disturbed by posterior position because the uterus remains too large to return to the sacral hollow. In the latter weeks of the puerperium, retroversion is a common cause of subinvolution and prolonged vaginal bleeding. It is amazing to note the change in the large, soft uterus after replacement and the use of the pessary. The uterus becomes small and firm within a few days, the flow usually ceases, and the patient feels much improved. This situation is one of the best reasons for the use of a pessary. The support is worn for at least three months. Then if the uterus was originally anterior, it will usually remain so; if originally posterior, it will usually return to the posterior position, but is not apt to cause symptoms. Pregnancy rarely corrects posterior position of the uterus. May I say here that the pessary has no miraculous power to replace the uterus, it only maintains the posture after manual correction. Used without correction, it may only serve to aggravate the symptoms.

Other Effects

If retroposition of long-standing is present throughout the menopausal years in the woman who has borne children, I believe that benign bleeding is more apt to occur. This is probably due to the effects of chronic congestion, with resultant cystic change of the ovaries and increased fibrosis of the uterus. In such event, curettage should be used to eliminate malignancy and radium or X-ray therapy to control the bleeding, rather than replacement of the uterus.

Retroversion has been held responsible for the production of endometriosis by causing retrograde menstruation. I am not convinced of this. Retroversion of the uterus may be a factor in aiding prolapse of the uterus, but this also implies marked loss of uterine tone and support. Backache is more apt to be caused by sacroiliac strain than by uterosacral strain, and leukorrhea by disease of the cervix rather than by a posterior fundus.

In general, I believe that the potentialities for disease are greater when the uterus is in retroposition than when it is in the anterior position. Surgery should be advised only when the symptoms demand correction and when, if possible, a pessary has proved that correction of the position will cure the patient.

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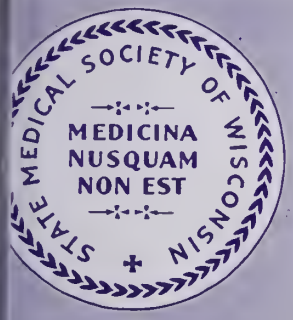

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CANCER OF THE CERVIX
By A. H. Curtis, M. D.
EXAMINATION OF INDUSTRIAL WORKERS
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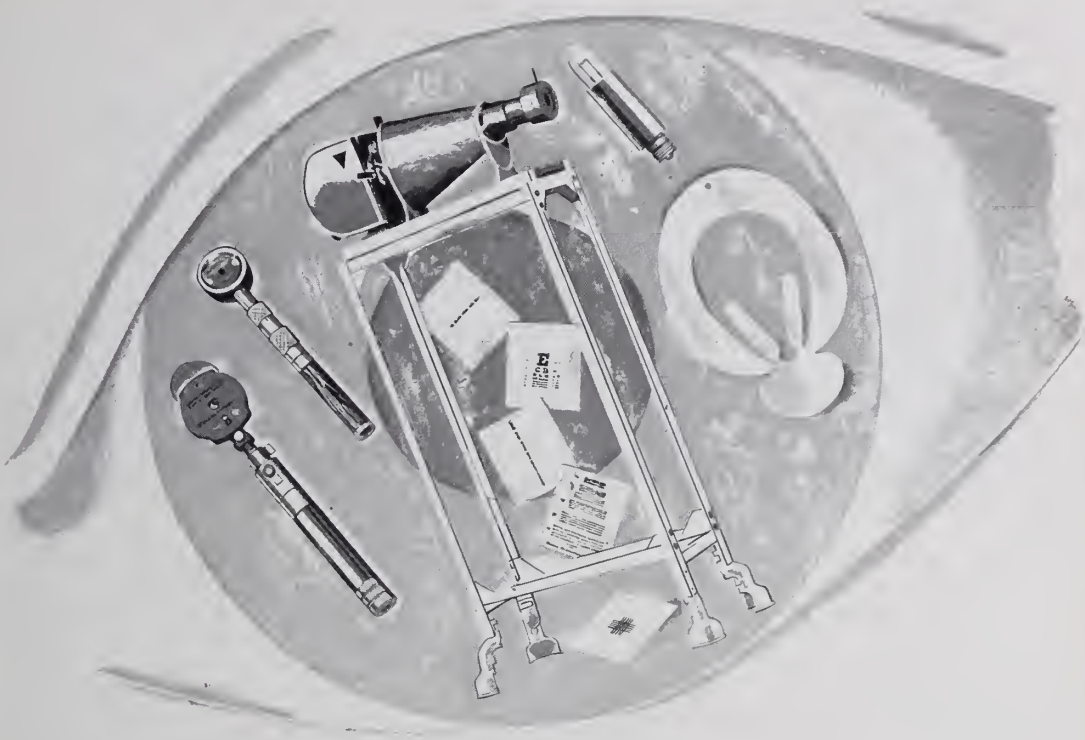

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Many researches (2) have established that a deficiency of iodine in food and water may produce a derangement of the thyroid gland known as simple or endemic goiter. The management of this condition, once present, is properly a matter for competent medical attention. However, it is agreed that normally the prevention of endemic goiter is purely a nutritional problem and that control of this disorder can be effected by providing for an adequate daily supply of iodine. It has been suggested (1, 2) that the probable human iodine requirement lies between 0.05 and 0.10 milligram per day, the higher amount being indicated for children and for pregnant and lactating women.

Due to the fact that the foods and water in certain regions—especially the so-called "goiter belt"—are low in iodine content, obviously some means of enhancing the iodine intake of persons residing in such localities should be provided. For this purpose, iodized salt has been proven most effective and is commonly favored for use under such circumstances (3). However, the low incidence of endemic goiter in seaboard localities—in which the plant and animal foods are exceptionally high in iodine—suggests the potential value of food sources of iodine.

Under normal circumstances, in goiterous regions, main dependence should be placed on iodized salt as a source of iodine. However, the value of foods high in content of this essential mineral should not be overlooked. As indicated above, foods grown in the coastal areas are exceptionally high in iodine; in addition, fish and marine products from coastal waters are also rich food sources of this element. Consequently, such foods—many of which are available as commercially canned foods—should serve as economical and convenient supplementary sources of iodine. Through intelligent use of iodized salt and the available food sources of iodine, an optimal daily supply of this dietary essential should readily be obtained.

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REFERENCES

(1) 1939. Mineral Metabolism, Alfred T. Shohl, Reinhold, New York, N. Y.

(2) 1939. Food & Life, Yearbook of Agriculture, U. S. Dept. of Agriculture, U. S. Govt. Printing Office, Washington, D. C.

(3) 1939. General Decisions, Council on Foods, Amer. Med. Assoc., Chicago.

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STUDIES IN THE AVITAMINOSES

This page is the ninth of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the August 17 issue of The Journal of the American Medical Association.

Casal's collar in a patient with advanced pellagra secondary to chronic alcoholism.

Illustration courtesy of Virgil P. W. Sydenstricker, M.D., University of Georgia Medical School, Augusta.

The scaling symmetrical pellagrous dermatitis of the hands.

The Dermatitis of Pellagra

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The dermatitis which frequently appears on the neck is known as Casal's collar. The lesion assumes its peculiar distribution because of the provocative action of sunlight upon the skin of pellagrins. The neck, exposed to the influence of sunlight, is thus frequently the site of the pellagrous dermatitis. However, unexposed portions of the skin, notably the upper thighs and perineum, may become similarly involved.

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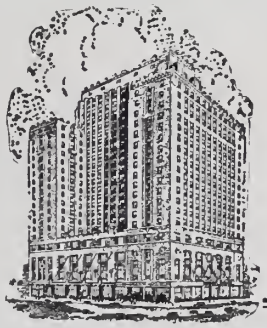

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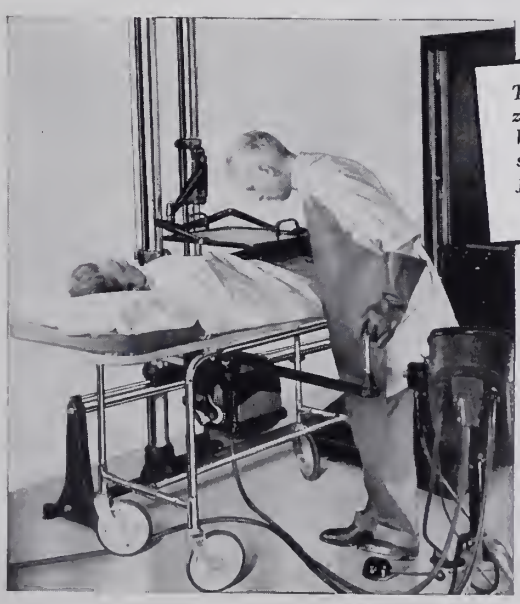

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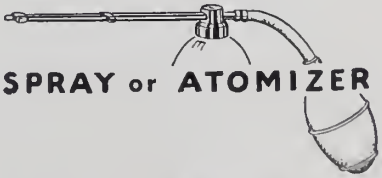

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THE WISCONSIN MEDICAL JOURNAL

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The Sex Hormones*

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Anterior-Pituitary-Gonad Relationship in the Female

ANTERIOR–PITUITARY HORMONES—The anterior pituitary gland is supposed to secrete two gonadotropic hormones, namely, the follicle stimulating hormone and the luteinizing hormone. It is still a disputed question whether these are two distinct hormones or whether these two effects on the follicle are the result of the action of a single hormone under different conditions occurring during the normal menstrual cycle.

Cole and Hart,[1] 1931, observed a substance in high concentration in the serum of pregnant mares, which, in activity, closely simulates the action of anterior pituitary gonadotropic extracts. It produces follicle stimulation, ovulation and luteinization. In 1937, Cartland and Nelson,[2] prepared a highly purified extract of this gonadotropic principle and assayed it biologically. This extract must not be confused with the anterior-pituitary-like substance found in pregnancy urine. It differs biologically and chemically from all other gonadotropic substances studied, and its action resembles that of extracts and implants of the anterior lobe of the pituitary gland. Unlike the gonadotropic substance (APL) found in the blood and urine of pregnant women, this fraction from mare serum is not excreted in the urine at any time during gestation, and is not filterable through collodion membranes. It appears to be a peptide.

Davis and Koff[3] administered this extract intravenously on varying days of the menstrual cycle to thirty-six women who were awaiting abdominal operation for various pathological conditions. When laparotomies were done it was observed in about half of the women that ovulation had occurred recently. The evidence was obtained by gross inspection and microscopic examination. The time that elapsed between administration of the gonadotropic substance and ovulation in these patients was unusually short; apparently, under this stimulation, the follicles ripen, ovulation occurs and the ruptured follicle is converted into a corpus luteum within twenty-four to thirty-six hours.

Ovarian Hormones

a. *Dihydrotheelin.*—Doisy and co-workers[4] on March 22, 1935, reported the isolation of an ovarian follicular hormone in crystalline form from the follicular fluid of pigs' ovaries. This is the only estrogenic hormone that has been proved to be secreted by the follicle of the ovary. It seems to be identical with a reduction product which was made synthetically and which was also known as dihydrotheelin. However, Dr. Doisy's group has shown indirectly that there is theelin activity in the follicle fluid.

b. *Progesterone.*—Progesterone is the official name for the luteinizing hormone secreted by the corpus luteum of the ovary. The name progesterone is a combination of two names for the same hormone, namely, progestin, isolated by Corner and Allen[5] of the University of Rochester, and luteosterone, isolated by Butenandt and Slotta[6] of Germany. Therefore, the word progesterone is a contraction of the two terms used for the same substance. Progesterone has been produced synthetically from pregnandiol, which is found in the urine of pregnant women and also from stigmasterol, a wax obtained from soy beans. It has been found that if progesterone is injected into the body

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it can be almost completely recovered in the urine as pregnandiol, indicating that pregnandiol is an oxidation product of its precursor, progesterone.

Excretion of Pregnandiol

It was not until 1937 that Venning and Browne[7] recognized pregnandiol as an excretion product of progesterone, found in small amounts in the urine of women during the luteal phase of the menstrual cycle and in pregnancy urine. The greater amount of progesterone secreted by the corpus luteum is reduced to a compound known as sodium pregnandiol glycuronide.

With this knowledge, Venning and Browne made a quantitative study of the excretion of sodium pregnandiol glycuronide in the urine of normal women. It is only excreted in the luteal phase of the menstrual cycle and appears in the urine within twenty-four to forty-eight hours after ovulation. The excretion of the product is continuous for a certain period, varying from three to twelve days in the cases studied by Venning and Browne. In six of their ten cases the period of excretion was ten to twelve days. Bleeding occurs from three to four days following its disappearance from the urine.

Since pregnandiol is a reduction product of progesterone, and as the molecular weights of these two substances are almost identical, the amount of pregnandial excreted may be conveniently compared to an equivalent weight of progesterone from which it is derived. The total amount of pregnandiol excreted per period varies from 3 to 45 mg., and the average amount excreted during the cycle appears to be about 40 to 55 mg.

The measurement of this compound in the menstrual cycle offers a means of determining the duration and functional activity of the corpus luteum.

Hamblen and associates[8] studied a group of normal women and others having various alterations in ovarian function, to correlate secretion of progesterone and excretion of pregnandiol (sodium pregnandiol glycuronide) with changes in the endometrium. The daily urinary excretion of sodium pregnandiol glycuronide was determined by the method of Venning. The data secured led to the following conclusions: Four factors are concerned in the metabolism of progesterone and in the subsequent urinary excretion of sodium pregnandiol glycuronide: (a), *ovarian*, involving the formation of progesterone by post-ovulational corpora lutea and possibly from the marginal granulosal luteinization of follicles; (b), *endometrial*, concerned with the alteration of progesterone into pregnandiol; (c), *hepatic*, which brings about the conjugation of pregnandiol with glycuronic acid; and (d), *renal*, involving the excretion of sodium pregnandiol glycuronide.

The excretion of this compound indicates the functional capacity of all these factors; the absence of the compound from the urine indicates the functional failure of one or more of the factors. A failure of excretion is not conclusive evidence that ovarian function is inadequate. The secretion of the pregnandiol complex is not evidence that an endometrium is undergoing progestational proliferation. As a corollary to this, bleeding which occurs from an estrogenic endometrium is not proof that the ovaries are not forming progesterone.

Placental or Urine Hormones

The placental hormones are supposed to be secreted by the placenta and are chiefly recovered from pregnancy urine, but may be recovered to some extent from amniotic fluid.

a. *Dihydrotheelin—(Estradiol)*.—Doisy and co-workers recently isolated dihydrotheelin in crystalline form from pregnancy urine. There is no proof at present that dihydrotheelin is secreted by the placenta. However, the isolation of crystalline dihydrotheelin from pregnancy urine vitiates the idea that theelin (estrone) is an excretion product of dihydrotheelin (estradiol).

b. *Theelin*.—Zondek and Aschheim in 1927[9] found that the urine of pregnant women contains large quantities of estrogenic hormone. Doisy,[10] using such urine, was the first to isolate an estrogenic hor-

mone in crystalline form and this he named theelin. November, 1938, Doisy and coworkers[11] reported the isolation of crystalline theelin from human placenta.

c. *Theelol.*—Theelol is another estrogenic substance which was isolated from pregnancy urine at about the same time by Doisy of St. Louis and Marrian[12] of England in 1931. Browne, 1931, isolated crystalline theelol from the human placenta.

d. *Emmenin.* — A third estrogenic substance known as emmenin which is very similar to theelol was isolated by Collip.[13, 14] Theelol differs from emmenin in that theelol is ether soluble and emmenin is ether insoluble. It has since been found that emmenin is the glycuronide of theelol, and is water soluble.

e. *Anterior pituitary-like hormone* (APL).—Aschheim and Zondek,[15] in 1927, found a substance in pregnancy urine which they named prolan and which was at first thought to be the anterior pituitary gonad stimulating hormone, but this has been disproved. APL is definitely not the gonadotropic hormone of the anterior pituitary gland. APL or prolan is the substance that exists in the urine in pregnancy that is responsible for the production of the Aschheim–Zondek and Friedman tests for pregnancy.

So that there will be no confusion, the hormones that have to do with sex in the female will be briefly reviewed. The anterior pituitary gland produces the follicle stimulating hormone and the luteinizing hormone. The ovary secretes the estrogenic hormone, dihydrotheelin, and progesterone, the luteinizing hormone. The placenta supposedly secretes theelin, theelol, emmenin and APL.

The Normal Menstrual Cycle

The follicle stimulating hormone of the anterior pituitary gland causes graafian follicle development and as this structure matures the follicular hormone is secreted which in turn produces the growth phase in the endometrium. After rupture of the mature graafian follicle and extrusion of the ovum (twelfth to sixteenth day) the luteinizing hormone of the anterior pituitary gland causes the development of the corpus luteum. The corpus luteum then continues to secrete the follicular (estrin hormone) in increasing amounts, plus progesterone (luteal hormone) which produces the premenstrual changes in the endometrium, characterized by increased vascularity. The glands become tortuous and distended with secretion and the stroma contains much nutritive material such as glycogen.

The follicular hormone is produced in increasing amount to about the twenty-fourth day of the cycle and, as this occurs, it gradually inhibits production of the follicle-stimulating hormone of the anterior pituitary gland. As the follicle-stimulating hormone of the anterior pituitary gland diminishes, it reaches a point at which the amount is insufficient to maintain the corpus luteum. As the corpus luteum regresses, there is a rather sudden decrease and finally cessation of estrin production, with a resultant disintegration of the premenstrual endometrium (menstruation). With the absence of the follicular hormone, the inhibitory influence of this substance on the anterior pituitary gland is removed, again allowing production of follicle stimulating hormone, and the initiation of a new cycle.

Physiology of Theelin in the Human Castrate

The human female, female apes and old world monkeys are the only animals that menstruate in the ordinary sense of the term.

Werner and Collier,[16] St. Louis University, duplicated on the human female castrate the work of Edgar Allen[17] on the monkey. They also were able to check on the symptoms complained of by castrates which could not be determined on the monkey. The following are the conclusions on the first human experiment:

1. Theelin restores the breasts and genital tract of women to apparently the normal sexual state after previous castration atrophy.

2. Theelin produces changes in the atrophied endometrium of castrated women that approximate or equal the interval changes found in the normal woman at the time of ovulation.

3. Theelin does not produce the pregravid changes in the endometrium of castrated women.

4. The bleeding from the uterus of castrated women induced by theelin occurs from an endometrium approximating or equaling in development the interval changes found in the uterus of normal women.

5. Theelin induces bleeding from the uterus of castrated women qualitatively indistinguishable from menstruation in normal women.

6. This bleeding from the uterus of castrated women is accompanied by the subjective symptomatology usually experienced by normal women during menstruation.

7. Theelin relieves the subjective symptoms that occur in women following castration.

8. Four ovariectomized women to whom large doses of theelin were given state that "libido was markedly increased."

9. Excessive doses of theelin were given to women intramuscularly over a period of from eighty-nine to ninety-three days without seeming discomfort, until a dosage of from 6 to 8 cc. daily was reached.

In a second experiment in which eight castrated girls were used, Werner and Collier[16] duplicated the results obtained in the original experiment, besides finding that 2,800 rat units would initiate endometrial growth when the element of time is taken into consideration.

In a third experiment by Werner and coworkers,[18] in which sixteen castrated girls were administered theelin in oil in varying dosages, the following conclusions were determined:

1. Theelin in oil stimulates development of the sex-related structures of the human female, producing changes in the breasts, gross appearance of the vagina, with increased mucous secretion, and growth of the endometrium and vaginal mucosa, in dosages as low as 5,000 international units.

2. Definite changes in the vaginal smears were noted with dosages of theelin in oil as low as 10,000 international units. Vaginal smears would appear to be a less delicate index of theelin administration than uterine mucosal specimens. Relief of symptoms of castration was obtained with dosages as low as 5,000 international units, which is insufficient to produce the full follicular phase in the vaginal smears.

3. This experiment proved that dosages of 5,000 international units of theelin in oil, when the element of time is considered, will mitigate or relieve the symptoms of castration, but at the same time will stimulate development of the endometrium sufficiently to cause uterine bleeding when discontinued.

4. Theelin in oil is much more effective than theelin in aqueous solution. When administered intramuscularly in the human, smaller dosages and less frequent intervals of injection produce more rapid and more marked effect on the endometrium and vaginal mucosa.

5. The evidence seems conclusive that the large dosages of theelin advocated by some (from 30,000 to 50,000 rat units), as necessary to produce the interval phase of the endometrium, are grossly excessive.

Treatment of Gynecologic Conditions

In the treatment for relief of the syndrome characteristic of castration, ovarian hypofunction, menopause and involutional melancholia, estrogenic hormones are indicated. Any of the standard preparations of the estrogenic hormones which have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association may be used to relieve these symptoms.

One thousand or 2,000 international units of estrogenic hormone, based upon experience with theelin or estrone, may be injected three times a week into the upper third of the gluteal muscle, alternating sides each time. A small strip of adhesive tape 1 x 1 inch should be placed over the injection site immediately, for oil solutions may leak out if this is not done. In severe cases, such as involutional melancholia, it may be necessary to inject 2,000 to 5,000 international units of estrogenic hormone daily during the first month, and then revert to injections every other day. With improvement in many of these conditions after the first month or two,

treatment should be continued for from three to six months. In some instances, where patients do not show improvement within one to two months, it may be necessary to inject much larger doses than stated above.

The only criterion as to whether the patient has attained the glandular adjustment characteristic for the postmenopausal period is to discontinue treatment; if the symptoms do not return the patient is well. If the symptoms do return, then treatment must be reinstituted for from one to two or three months, again depending on the severity of the symptoms.

Estrogenic hormones have also been recommended for treatment of amenorrhea, menstrual disorders and the various disturbances frequently associated with the menstrual cycle; also in gonorrheal vaginitis, some types of sterility, nausea and vomiting of pregnancy, acne and other kindred conditions.

Progesterone has been recommended in primary amenorrhea, to be administered intramuscularly. The course should consist of injections of 2,000 to 5,000 international units of estrone every other day for three weeks, during the last week of which one to five units of progesterone should be added. The purpose of this treatment is to stimulate development of the premenstrual endometrium. After the cessation of injections during the fourth week, the patient should menstruate if the treatment has been effective.

It should be effective in functional uterine bleeding, given during the third week of the cycle, if the functional bleeding is due to deficiency of progesterone. However, if the functional uterine bleeding is due to an incompletely developed follicle, then the ideal treatment would be injections of a potent gonadotropic hormone (not APL).

When sterility is due to insufficient progesterone to produce the premenstrual endometrium, then it should be effective in this condition.

It is effective in some cases of threatened and habitual abortion, by inhibiting the premature uterine contractions due to estrogenic hormones and oxytocin. For the same reason, it has been recommended for the relief of afterpains (postpartum).

Male Sex Hormones

Butenandt,[19] 1931, isolated a crystalline substance from human male urine having the empirical formula $C_{19}H_{30}O_2$. He named this substance "Androsterone." Solutions of this compound when injected into the capon caused growth of the comb and wattles.

Ruzicka,[20] by a series of chemical reactions, produced androsterone synthetically from cholesterol. The formula of his compound is the same as that isolated from male urine by Butenandt ($C_{19}H_{30}O_2$) and when this substance is injected into the capon, the effects are similar to those produced by androsterone (Butenandt).

David, Dingemanse, Freud and Laqueur,[21] 1935, isolated a crystalline hormone from testicular tissue of the bull, having the empirical formula $C_{19}H_{28}O_2$ which they named "testosterone."

Butenandt[22] and Ruzicka,[23] 1935, prepared testosterone synthetically by degradation of cholesterol. Testosterone is more potent biologically than androsterone.

Butenandt, in 1934,[22] also isolated a second crystalline substance from human male urine, having the empirical formula $C_{19}H_{28}O_2$ which he named "dehydroandrosterone." Dehydroandrosterone is an isomer of testosterone (from testicular tissue) and it is considerably less active than androsterone and much less active than testosterone. Butenandt, 1935, devised a method for its synthetic preparation from cholesterol, which was successfully utilized by Ruzicka in 1935. All sex hormones belong to the class of sterols and are closely related to cholesterol, the bile salts, etc.

Koch[24] states, "some thirty-five to forty androgenic compounds of known structure have been prepared thus far and have been studied comparatively for physiological activity."

Clinically, androgens and estrogens are excreted normally by both men and women. Studies reported by Koch[25] show that there are marked daily fluctuations in the urinary

excretion of androgens and estrogens in normal men and women. The average daily excretion of androgens is sixty-three to sixty-eight international units in men and forty-two to fifty-six units in women. The average daily excretion of estrogens, calculated as gamma of theelin, is nine to twelve gamma for men and eighteen to thirty-six gamma for women. In male castrates, exceedingly small amounts of sex hormones are found in the urine. In eunuchoids, the excretions of sex hormones are distinctly lower than in normal individuals. In gynecomastia, no excess excretion of estrogens was observed. In virilism there is a tendency toward a lower excretion of estrogens with a normal or higher excretion of androgens. In some cases of virilism with adrenal involvement, the excretion of androgens is exceedingly high.

Function of the Male Sex Hormones (Androgens)

The gonadotropic hormone of the anterior pituitary gland is necessary to stimulate the interstitial cells of Leydig to function, with consequent production of male sex hormones.

The male sex hormones then stimulate development of the secondary sex characteristics in the male. At puberty and during adolescence, there is growth and development of the seminal vesicles, the prostate and Cowper's glands, the penis and scrotum. Masculine bodily configuration occurs, along with hair growth characteristic for the male. The voice changes to a deeper tone and the male psyche develops, accompanied by libido, potency and sex consciousness.

The anterior pituitary gonadotropic hormone also stimulates the germinal cells of the seminiferous tubules to the production of spermatozoa, (spermatogenesis).

Treatment With Male Sex Hormones

Androgenic hormones, of which testosterone is representative, have been recommended for the treatment of hypogenitalism in childhood and adolescence, impotence and sterility in the male. Werner[26] described the male climacteric and reported the use of testosterone propionate (perandren) in this condition and in male castrates and male involutional melancholia. Beneficial results have been reported[27] from its use in benign prostatic hypertrophy.

Some competent workers have recommended the use of testosterone for certain sex hormone disturbances in the female, such as, to suppress lactation, to control functional uterine bleeding, menorrhagia and metrorrhagia, to relieve the menopausal syndrome, dysmenorrhea and painful breasts.

The action of the male sex hormone in the female would, theoretically, be inhibition of pituitary activity. It is conceivable that the action might also be a direct suppression of ovarian function, with a tendency to masculinization of the female if treatment were excessive or long continued. The author suggests that caution be exercised in the promiscuous use of male and female sex hormones for conditions of the opposite sex, for this is not the method of nature. It seems more rational to use these hormones in a manner comparable to their normal physiological functions in the human.

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PREPAREDNESS POLL

Physicians are urged to return IMMEDIATELY, if they have not already done so, the preparedness questionnaire of the Committee on Medical Preparedness of the American Medical Association. The entire medical preparedness program of the Association revolves around the data obtainable from these questionnaires.

Any Wisconsin physician who has failed to receive this material should request it from the American Medical Association, 535 North Dearborn St., Chicago, Ill.

Cholecystostomy versus Cholecystectomy and Instrumental Dilation of the Papilla of Vater*

By A. L. MAYFIELD, M. D.
Kenosha

FOR many years cholecystostomy was generally employed in the surgical treatment of biliary tract disease. At the present time it is used chiefly in the complicated inflammatory processes of the gallbladder and in the obstructive lesions of the common duct where the need for temporary drainage is indicated. This group of cases represents in reality only a small percentage of the total number of surgical lesions of the biliary tract.

In making a choice of operation the general condition of the patient is an important factor to consider. If the patient's condition is critical because of advanced age, systemic disease, or an acute infection of the gallbladder, a drainage operation is best. On the other hand, if the patient is a suitable risk for operation, cholecystectomy may be safely performed. In such cases the condition of the patient rather than the character of the pathologic lesion determines which operation is preferable.

Removal of the gallbladder is never urgent and to insist on removing it in a seriously handicapped patient is a dangerous procedure. Local technical difficulties due to a marked inflammatory exudate and vascularity in the region of the gallbladder and bile ducts obscuring anatomic relationships are indications for cholecystostomy. Cholecystectomy is not warranted in the presence of definite danger of hemorrhage or injury to the ducts. If operation is decided upon because of peritonitis due to perforation of the gallbladder, drainage alone should be employed. The serious condition of the patient in such circumstances will not permit a radical operation. Relief from jaundice is the first objective in debilitated patients with obstructive lesions of the common duct. The presence of acute cholecystitis associated with jaundice caused by a stone in the common duct makes an extensive operation hazardous. Frequently it is better to drain the gallbladder in such cases. When the acute infection and jaundice have subsided, the obstructing stone and the gallbladder can be removed with less risk.

The objection to the operation of cholecystostomy is based upon the fact that following removal of stones from the gallbladder and a drainage operation, the infection in the wall of the gallbladder cannot be depended upon to subside. As a result of residual infection in the gallbladder wall, reformation of stones in the gallbladder frequently occurs, and often the bile ducts become contaminated resulting in conditions favorable to stone formation in the ducts and extension of infection into the liver and pancreas. It is rare that stones are found in the bile ducts without stones in the gallbladder. This is evidence that infection and stone formation in the ducts are secondary to infection and stone formation in the gallbladder. Stones in the common duct often produce obstruction of the duct, jaundice, and diminished liver function resulting in secondary operation, increased morbidity, and mortality.

The principal reason for cholecystectomy in the presence of a diseased gallbladder is that the focus of infection and the site of stone formation are removed, thus preventing recurrence of stones in the gallbladder and secondary infection in the biliary tract. Excision of the gallbladder results in a loss of its storage and concentrating functions, a relaxation of the sphincter of Oddi, and a dilatation of the biliary ducts. Consequently bile is discharged into the duodenum continuously instead of intermittently. Stasis of bile, one of the factors in gallstone production, is thus removed and free drainage of bile is established. Removal of the gallbladder, the major site of infection in the

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biliary tract, and establishment of free drainage of bile into the duodenum are the essential changes responsible for subsidence of the disease. This operation has a wide field of usefulness and can be performed with little risk to the patient in most cases of acute and chronic cholecystitis.

Mortality and Other Factors

At one time the high mortality of cholecystectomy made it objectionable. At the present time the immediate mortality of cholecystectomy compares favorably with that of cholecystostomy and the ultimate mortality of cholecystectomy is lower. Experience has shown that the mortality rate increases in the group of cases in which there is recurrence of symptoms and secondary operation following cholecystostomy.

If the patient is a good surgical risk cholecystectomy does not carry a high mortality in cases of early acute cholecystitis. In acutely ill patients with this disease a drainage operation or delay may be indicated until the inflammatory process has subsided. No definite rule can be formulated for the surgical treatment of these patients, but early cholecystectomy is preferable if it can be accomplished while the disease remains localized. Removal of the gallbladder interrupts the pathological process and avoids the dangers of gangrene and perforation.

Prolonged drainage of the gallbladder has been the customary procedure in cases of acute and chronic pancreatitis associated with cholecystitis or stones. However, cholecystectomy with or without drainage of the common duct often accomplishes more in cases of chronic pancreatitis associated with lesions of the gallbladder than cholecystostomy. This is probably due to the combined effect of removal of the focus of infection and to the changes produced in the sphincter of Oddi by excision of the gallbladder.

In fat patients with adhesions around the neck of the gallbladder cholecystectomy may be difficult to perform. Occasional anomalies of the bile ducts add to the danger of the operation. The possibility of hemorrhage and injury to the ducts exists, but the results obtained justify the hazard. If the ducts are injured or hemorrhage occurs, it is likely that the surgeon has made an unwise decision in attempting to remove the gallbladder.

Cholecystectomy carries with it a shorter convalescence and in every way less morbidity than cholecystostomy. The end results are ordinarily good in 85 per cent of the patients treated whereas, in simple drainage, symptoms may be expected to persist or recur in 30 per cent of the patients treated. Cholecystostomy is still a valuable operation in the handicapped patient and in the complicated lesions of the biliary tract, but should be used only in operations of necessity where the existing emergency requires the least operative effort. Cholecystectomy offers the patient better protection from recurrence of the disease and its complications and a lower ultimate mortality than cholecystostomy. Both operations have a field of usefulness. No conservative surgeon will commit himself to either one as a routine. The choice of operation in each case must be made on the basis of individualization taking into consideration the operative risk presented by the patient, the existing pathological process, and the experience and skill of the attending surgeon.

No operation for gallstones is complete which does not include exploration of the ducts. Often attention is centered exclusively upon the gallbladder when the lesion producing the symptoms is present in the common duct. Removal of the gallbladder in such cases fails to relieve the symptoms for which the operation was undertaken. In every case of biliary tract disease the possibility of common duct involvement must be considered. In the absence of a history of obstruction of the common duct, pathological lesions of the ducts are apt to be overlooked. Jaundice is absent in 30 per cent of the cases with stones in the common duct. The common duct may be packed with stones without jaundice resulting and even without pain. If the common duct is dilated and thickened, it should be opened and explored even when the history of jaundice is negative and duct stones are not palpable. Dilatation of the common duct is evidence of disease within. In the majority of cases stones are responsible for the dilatation, and in the remaining

cases inflammatory changes in the duct outlet with associated pancreatitis are responsible.

In a certain group of cases recurrence or continuation of symptoms follows excision of the gallbladder and removal of stones from the common duct. Spasm of the sphincter of Oddi of neurogenic origin may offer a satisfactory explanation for the symptoms produced in some of these cases, but many cases apparently are secondary to organic lesions involving the bile ducts, pancreas, and duodenum. It should be emphasized that stones in the common duct are usually the cause of recurring attacks of colic and always should be regarded as the probable cause of pain until the duct has been opened and thoroughly explored. The greatest care sometimes fails to clear the duct of debris especially if a stone has been fragmented by attempts at removal.

Dilatation of Papilla of Vater

Because of the possibility of overlooking stones in the bile ducts, many surgeons in recent years have routinely dilated the papilla of Vater to a sufficient size to allow stones of small size to pass through it into the duodenum. In the past various instruments have been employed for this purpose, including probes, scoops, forceps, and urethral sounds. At the present time the olive-tipped bougies with bendable shafts proposed by Bakes[1] are frequently used. These dilators are graduated in size from a diameter of 3 mm. to 14 mm. Although Bakes advocated dilating the outlet of the common duct to a size just below that of the duct itself, it is probably a safer procedure to limit the dilatation to 9 or 10 mm.

In certain patients with a constricted outlet and large duct the papilla is dilated to a considerable size even up to a centimeter. The general surgical opinion has been that this procedure provides for the passage of small stones and prolonged drainage of bile into the duodenum so that "T" tube drainage is not often required. As a matter of routine, dilation of the papilla to 7 mm., followed by forceful flushing of the duct with salt solution is considered sufficient. In many cases in which there is an indication for opening the common duct, evidence of inflammation will be found which requires some type of drainage. Usually a small catheter drain is left in the common duct although some surgeons feel that internal drainage through the papilla is sufficient. Walton[2] states that since dilating the papilla as a routine measure he uses a tube drain infrequently and only in the presence of definite suppuration in the duct.

Complications following instrumental dilation of the papilla of Vater have been infrequent. Nevertheless, this procedure is not without danger. The size of the large dilators is considerable in relation to the size of the normal papilla. Care and skill are required in their use in order to avoid lacerations of the papilla and production of a false passage through the common duct and duodenum. Lahey[3] reported two cases of fatal gas bacillus infection following dilation of the papilla. In order to avoid this complication he now limits the dilation to 9 mm. One of Allen's[4] patients developed an acute hemorrhagic pancreatitis and died. It was a matter of conjecture in this case as to whether or not the dilatation was related to the pancreatitis. Later Allen purposely dilated the papilla in the presence of pancreatitis as a therapeutic measure. Prompt recovery followed. Davis[5] reported a death due to reflux of duodenal contents through the common duct. Enormous quantities of duodenal contents escaped which digested the tissues of the wound causing it to break down. This is a serious type of complication but, fortunately, a rare one.

Branch, Bailey, and Zollinger[6] carried out a series of experiments on dogs to determine the effect of instrumental dilation of the papilla upon the biliary tract. These investigations demonstrated that obstruction of the papilla occurred during the first week after dilation as a result of exudate in the duct and edema of the surrounding tissues. Furthermore, the experiments indicated that when the stage of obstruction passed, the lumen returned to its original size in approximately a week regardless of the extent to which it was dilated at operation. Thus, extensive dilation of the papilla did not enlarge the lumen either shortly after opera-

tion or later. This experimental evidence indicates that dilation does not accomplish its purpose of enlarging the lumen of the papilla so that unrecognized stones can pass.

Opposed to this view are the opinions of many surgeons who feel that routine instrumental dilation of the papilla of Vater is a relatively safe procedure and a logical means of providing for removal of unrecognized stones in the ducts. Even if temporary swelling of the papilla occurs after dilation, it is possible that small stones may be washed through it into the duodenum by irrigation at the time of operation. In many cases internal drainage alone has been employed after closure of the incision in the common duct. No immediate or remote signs of obstruction of the papilla have been recognized as a result of this procedure. Dilation of the papilla has been used in a large number of patients without adding appreciably to the operative mortality. Whether or not its use has been a factor in removing overlooked stones in the common duct has not been demonstrated. Further observation and follow up study of the patients treated by this method will aid in determining its value.

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DISCUSSION

Carl W. Eberbach, M.D., Milwaukee: I have listened to Dr. Mayfield's paper with a great deal of interest, and feel that what he has said reflects accurately the best thought on this subject today. However, I would like to say a few words about early operation in acute gallbladder and common duct disease.

Until recent years conservative treatment has, in general, been the procedure of choice in dealing with acute gallbladder and common duct disease. It seemed wiser to allow the acute processes to subside and to proceed with surgery at a later date. However, it is becoming more and more clear that in many patients under conservative treatment the disease fails to subside and surgical intervention under unfavorable circumstances becomes imperative.

My coworkers and I, in the study of our own cases, have gained certain impressions which have helped to guide us in the management of these lesions. Our mortality in all cases is 4.1 per cent. Breaking this down into chronic and acute cases, we find that the mortality in the chronic group is 1.7 per cent, while that in the acute cases is 7 per cent. It is obvious that if we want to reduce the mortality a study of the causes of death in the group with the highest death rate would be of first importance. We did this and found that in all of the acute cases conservative treatment had first been given with the hope that the acute processes would subside and that operation might be performed under more favorable circumstances. However this did not occur and for the most part these patients were operated upon under circumstances far less favorable than at the outset.

The conclusion to draw from these observations is that delay is the most important single factor responsible for our unsuccessful results in acute gallbladder and common duct surgery. We have therefore undertaken operation early in the acute group and have met with exceedingly good results in those patients operated upon within the first two or three days after the acute onset. To date, we have not a large enough series of cases to warrant drawing conclusions of importance. Reports in the literature, however, support the belief that early operation is the procedure of choice. Unfortunately many of these patients are not seen by the surgeon at an early date. They are usually put on conservative treatment by the family physician with the hope that the acute attack will subside, but many of them fail to improve. It becomes necessary therefore that the importance of early diagnosis and early surgical treatment in acute gallbladder and common duct disease be impressed upon the internist and general practitioner who see these patients first.

If time permits, I would like to add one more thought. We never do cholecystostomy unless compelled to by advanced age, complicating intercurrent disease, or insurmountable technical difficulties, though in a study of our operations upon the gallbladder and common duct, I find that cholecystostomy was done in 4.7 per cent of the chronic cases and in 25 per cent of the delayed acute cases. These figures indicate that many patients were subjected to much delay and neglect. All of them had had previous attacks and could have been dealt with safely and easily at the outset. I feel that we have all been remiss in pointing out to patients, after a diagnosis of surgical gallbladder and common duct disease has been well established, that these lesions are potentially dangerous and should be dealt with surgically at an early date. Procrastination in surgical gallbladder and common duct disease is frequently disastrous.

Management of Carcinoma of the Cervix*

By ARTHUR H. CURTIS, M. D.
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CERTAIN features of pelvic anatomy which have a direct bearing on our understanding and management of cancer of the cervix merit emphasis.

Cellular Tissues of Pelvis

I wish to direct your attention to the cellular tissues of the pelvis, for it is through them that infections spread, and cancer invades. Permit me to dwell for a moment on what "cellular tissue" really signifies. And to accentuate the importance of this, let me emphasize that the pathway of the lymphatics and blood vessels is entirely by way of the cellular tissues, and that knowledge of the latter therefore portrays in exact detail the route by which cancer spreads.

Cellular tissue is comprised of connective tissue cells and may serve as loose packing, as in the areolar tissue within the broad ligament, or may be more dense, tense and firm, thus constituting ligamentous tissue. Furthermore, the connective tissue fibrils may serve as a filler, or they may form a firm fascial covering or a thin more or less incomplete sheet, gradually fading away like the thin bark on a white birch tree.

Figs. 1, 2, and 3 illustrate the detail of cellular tissues in their relation to the female genitalia.

The spread of cancer is inevitably through the cellular tissues along the fascial planes which have been depicted. With detailed knowledge of the cellular anatomy of the female pelvis now available,[1] local metastases may be expressed in terms of interstitial involvement, superseding our heretofore hazy understanding of lymphatic drainage. Palpation of the tissues in an attempt to evaluate the invasion of these anatomically definite routes of extension promises to yield more trustworthy deductions relative to the extent of the malignant process; likewise, evaluation of the condition of the cellular tissues as well as the glands encountered at operation should be preferable to attention concentrated on palpation of the lymph nodes.

Carcinoma of the Cervix

I shall omit consideration of the operative treatment of this affection, and also, because of lack of space, shall content myself with a summarized listing of essential details in the nonoperative management.

1. A well trained gynecologist should be able to diagnose carcinoma of the cervix from its gross appearance alone, in nearly all instances. I have no brief against routine preliminary removal of fragments of tissue for biopsy study before venturing a diagnosis, but I do not often resort to this procedure. On the other hand, I frequently find that establishment of a certain diagnosis necessitates examination under anesthesia, often with instrumentation to provide adequate exposure and to determine the ex-

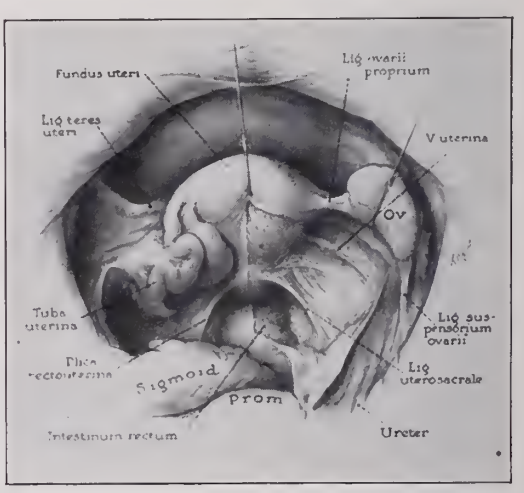

Fig. 1. Broad ligament, uterus; subperitoneal level. Posterior view. The uterus and ovary (with uterine tube) have been elevated; the peritoneum has been removed from the right half of the body of the uterus and, with it, the posterior leaf of peritoneum of the broad ligament. Thus are exposed the various subdivisions of the parametrial tissue.

* From the department of obstetrics and gynecology, Northwestern University Medical School and Passavant Memorial Hospital. Presented before the 98th anniversary session of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

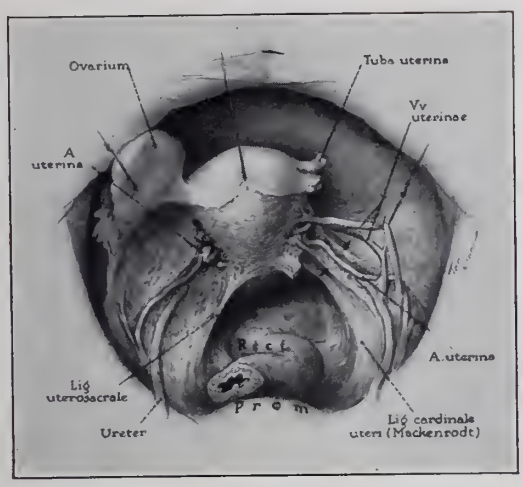

Fig. 2. Structures within broad ligament, vascular (mobilized) and ligamentous (defined or cut). On the right side the uterine tube and the round ligament have been cut near the uterus, the structures inferior to the tube shown in detail—the contents of the whole ligament now being of chief interest, in their interrelationships. The uterine tube and round ligament have been removed except at their uterine extremity, the thinner part of the parametrium dissected away to expose the cut margins (at arrows) of the heavier tissue which houses the uterine vessels; thus is shown the thickened basal part of the parametrium which becomes the cardinal ligament. On the left side, for purposes of comparison, only part of the fibrous tissue has been removed; the difference between tissue superior and inferior to the vessels is made evident.

act nature of atypical or hidden areas. I not only condone such examinations, but would emphasize the value of the study of cervical cancer patients when thus asleep, in order to evaluate the intricacies of the therapeutic problem which confronts us.

At the time of the examination in the operating room it is my custom to state definitely, "It is," "It is not," or "I do not know whether it is cancer." Treatment is instituted immediately in nearly all instances, delayed only in that small percentage of cases in which the diagnosis is in doubt and must await microscopic examination. Tissue is invariably taken for biopsy to make final confirmation of the diagnosis and for determination of the type of growth.

2. In the event that no malignancy is grossly recognizable, which usually means that malignancy is unlikely, the diseased area should be removed in toto as a prophylactic and diagnostic measure, the entire excised tissue immediately sliced for gross inspection, all of the several pieces so obtained being thereafter imbedded for microscopic study of one or more sections from each. I rarely find it helpful to resort to the Schiller test or colposcopic examination, but believe we should remain somewhat open-minded about the latter.

3. In nonulcerated, noninfected cases of cancer with a favorable prognosis, i.e., stage 1 and stage 2 clean cases, treatment with a tandem of radium capsules within the canal, together with radium needles imbedded in a palisade encircling the cervix, is indicated. Some maintain, and probably with reason, that radium within the canal together with radium placed against the cervix is equally efficacious. I usually employ a dosage varying from 3,500 to 4,500 mg. hr. No further radium treatment is required for many months, at least, in these clean cases.

4. In all cases of cervical cancer with a serious prognosis an intravenous pyelo-ureterogram is indicated, in order to determine whether there is involvement of the urinary tract.

5. Ulcerated or craterous necrotic cancer must be healed on the surface before inten-

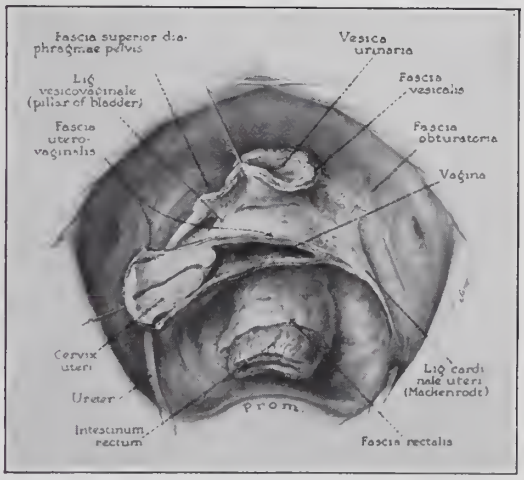

Fig. 3. Endopelvic fascia (visceral investments); ligamentous supports of the viscera. The bladder has been cut down to the trigonal portion, leaving, however, the ureter on the left side. The cervix of the uterus and the vagina (upper two-thirds) have been halved sagittaly, the uterine collar of endopelvic fascia separated from the muscular wall. On the right side a similar continuity is demonstrated —as is the relation of the fascial collar to the cardinal ligament. By drawing apart the bladder and the uterus, the fusion of their adjacent collars (laterally the fusion producing a ligamentous connection) is evident. The looser fascial collar of the rectum is also mobilized.

sive radiation, to avoid the danger of pelvic cellulitis. Surface healing may be accomplished with surgical diathermy or with a palliative radium application of 1,000 to 1,500 mg. hr., preferably in a bomb. Many weeks later, after healing of the necrotic surface, radium treatment may be given as described in noninfected, favorable cases.

Some of this group cannot be radiated adequately without endangering the bladder or ureters; in such instances, simple vaginal dissection readily displaces them out of harm's way. With the bladder safely anchored in an elevated position we may give intensive radium treatment, with selective implantation of needles in the musculofascial parametrial tissues aided by radium capsules within the uterine canal.

After preliminary radium treatment has healed the surface, conservative treatment with a radium bomb against the cervix is instituted in deeply craterous and other relatively advanced cases, painstaking care being taken to avoid destructive over-treatment. In hopelessly extensive and deeply ulcerated cases no therapy other than x-ray treatment may be given; even this should be administered with caution, for the possibility of cure is slight and that of doing harm is great.

6. Intensive high voltage x-ray therapy is instituted immediately, in all cervical cancer cases, as soon as a diagnosis is established, the patient being carefully watched and guarded against the hazard of over-treatment, which is considerable. X-ray therapy is a great boon. But, as we learned some years ago, it is not innocuous; thus, in one bad case, in which treatment was intensive, there was leukopenia, a clinical picture of agranulocytosis, and the patient died with myriads of small ulcerations of the colon, not a vestige of cancer discoverable at autopsy.

7. And now for a suggestion to which many of you may not be receptive: Howard Kelly was right when he stated that 85 per cent of the value of radium therapy lies in the first treatment and 85 per cent of the harm which we do is ascribable to subsequent radiation. But that dictum, admirable with the knowledge and methods of early days of radiation therapy, is no longer applicable with our somewhat widened vision. The extent of the cancerous lesion cannot be accurately appraised in the majority of serious cases at the time of the first treatment. Therefore I have found it immeasurably helpful to make another painstaking study, under anesthesia, almost routinely, several months, or a year or more, subsequent to the first intensive treatment with radium. One can then determine with considerable precision, and in detail, what has been accomplished. Such an examination should, of course, be made with radium ready, and with instruments prepared for simple surgical intervention to insure satisfactory placement of the radium.

I pause to cite only one of many cases in point. A patient was brought to me with a history of prolonged, supposedly functional bleeding. Palpation was negative, but I suspected a hidden cancer. Examination under anesthesia revealed an endocervical malignancy, the cervix a craterous shell, the bladder resting on a thin film of cervix anteriorly, the cervicovesical wall so thin that it felt like a fluctuant fetal sac. Tissue was obtained for histological study; with fear and trembling I gave 800 mg. hr. of radium within the canal, then instituted x-ray treatment, and three weeks later applied a radium bomb to the cervix. After four months, examination under anesthesia revealed smoothly healed surfaces, the cervix a firm thin shell, anteriorly of tissue paper thinness. The bladder was mobilized by blunt dissection and shoved upward, the uterus pulled downward so that the internal os became the external os, and then it was possible to treat with intensive radiation. The patient has remained free from evidence of cancer on repeated examinations under anesthesia.

8. Cancer of the cervical stump may be treated by radiation alone, but I prefer removal and radiation in cases with the growth apparently limited to the cervix. I employ radiation followed by subsequent removal in all other cases except those which are hopelessly extensive. My advocacy of surgical removal, in preference to x-ray-radium radiation alone, is prompted by bad results from treatment solely with radiation therapy, also by the simplicity of vaginal re-

moval of the cancerous stump, and by the fact that it is usually impossible to estimate the extent of the cancerous process in these cervical stump cases and therefore difficult to determine the amount of radiation required without exploration to reveal the stage of the disease. These views relative to the management of cancer of the cervical stump are still in a state of flux, subject to revision.

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Author's note.—I wish to acknowledge the cooperation of my co-worker, Dr. Barry J. Anson, in an intensive study of pelvic anatomy, both in the operating room and in anatomical dissections. Not only because of his originality in the pursuit of gross anatomy, but also because of his keen interest in the adaptation of what we have learned in the solution of clinical problems, I am particularly grateful to him.

Severe Hyperemesis Gravidarum With Avitaminosis

Report of Two Cases*

By CURTIS J. LUND, M. D.
Madison

THE milder forms of hyperemesis gravidarum do not ordinarily endanger the life of the mother or fetus and usually terminate satisfactorily after adequate conservative therapy. The advanced or severe forms of the disease are not so amenable to therapy and too frequently terminate with the loss of the fetus and often the mother. Recently two patients illustrating the severe type of hyperemesis gravidarum were admitted to the Wisconsin General Hospital.

Case Reports

Case 1.—A white primipara, age 23, was admitted to the hospital in the sixteenth week of gestation. She had been vomiting persistently for eight weeks and for the past ten days had retained nothing by mouth. Therapy prior to admission consisted of parenteral fluids and some form of endocrine therapy. The referring physician felt that termination of pregnancy would probably be necessary as a life-saving measure. At the time of admission the patient was so stuporous and mentally confused that a history could not be obtained. Her family reported that the patient had lost forty pounds in weight and that for the past two weeks she was unable to walk because of weakness.

Physical examination revealed the temperature to be 100.6 F., pulse 156, and respirations 24. She was mentally confused, restless and stuporous. Marked dehydration and emaciation were manifest. The skin was pale, warm, very dry and inelastic. There was nystagmus, enophthalmus and inequality of pupils, but the eye grounds were normal. The tongue was very dry and atrophic with a patchy glossitis. Reflexes were normal; sensorium was normal; there was muscle weakness.

Laboratory findings of significance were albuminuria, ketonuria and urinary casts. Examination of the blood showed hemoglobin 12 grams and erythrocytes 4,400,000. These values dropped immediately to hemoglobin 9.8 and erythrocytes 3,700,000 as soon as hemoconcentration was overcome. The blood sugar was 68, nonprotein nitrogen 25, alkali reserve 38.2, chlorides 460, proteins 4.3 with an albumin-globulin ratio of 1.7.

Progress was satisfactory. A daily parenteral fluid intake of 3,500 cc. was maintained, this included 10 per cent glucose given intravenously and saline and lactate Ringer's solutions given subcutaneously. Vitamin B complex (20 milligrams) and ascorbic acid (100 milligrams) were given hypodermically twice daily. Nothing was given by mouth. Barbiturates were used for sedation when necessary. A 500 cc. blood transfusion was given to combat anemia. On the third hospital day the patient was able to retain small amounts of alternate liquid and dry feedings. Proteins were added gradually, first in the form of egg albumin and then of meats. As soon as possible vitamins A and D were given by mouth. Emesis occurred only on five occasions after feedings were started and ceased after the tenth day. An average weight gain of three-fourths pound per day followed. Pregnancy terminated normally at term.

This patient exhibited findings characteristic of vitamin B deficiency along with dehydration, acidosis, low chlorides, hypoproteinemia and starvation. Saline given subcutaneously replaced the chlorides, and, when they were normal, lactate Ringer's solution was used. The glucose was given intravenously only. Protein restoration was accomplished by dietary measures. The voracious appetite and rapid weight gain were outstanding.

* From the department of obstetrics and gynecology, University of Wisconsin Medical School. Investigation aided in part by a grant from the Wisconsin Alumni Research Foundation, Madison.

Case 2.—A white tertipara, age 27, was admitted to the hospital in the thirty-second week of gestation. This patient had been vomiting for twenty-eight weeks; at first there was only a rather mild hyperemesis occurring two or three times daily, but it continued daily in spite of treatment by her physician, and persisted continuously as mentioned. During February she developed pyelitis of pregnancy with fever (the temperature was 102 to 104 F. daily). This was followed in three weeks by bronchopneumonia and the patient was taken to a hospital. After three weeks the chest condition responded to therapy. Nevertheless, the emesis became worse and only a few liquid foods were tolerated, these being supplemented by parenteral fluids. Rapid weight loss ensued. The skin became rather dark and there was considerable irritation and scaling of the hands. Short periods of mental confusion and irrationality were observed. After her return home, weakness became profound. Other new symptoms were soreness of the mouth and blurring of vision. The day before admission to this hospital she became completely irrational and confused.

At the time of admission the temperature was 97 F., pulse 138, and respirations 24. She was completely disoriented and quite agitated. Physical examination showed extreme degrees of emaciation and dehydration. The skin was dry and fine scaling was present on the dorsal surfaces of the hands. The breath was heavy with the odor of ketone bodies. The eye grounds showed many linear hemorrhages along the vessels. The tongue was dark brown, thick, very dry and atrophic. The heart was overactive but except for tachycardia was not unusual. The blood pressure was 130/100. The uterus was enlarged above the umbilicus and fetal heart tones were present.

Laboratory studies of urine revealed gross albuminuria, ketonuria and pyuria, also a few casts. Hemoglobin was 8.9 grams, erythrocytes 3,700,000, leukocytes 14,700 with normal differential count. Blood sugar was 81, nonprotein nitrogen 36, alkali reserve 35.2, chlorides 549, proteins 5.8 grams with albumin 2.2 and globulin 3.6, a ratio of 0.6.

Immediate treatment towards acidosis and dehydration consisted of 10 per cent glucose given intravenously, lactate Ringer's solution given subcutaneously. Thiamin chloride (50 milligrams), cevitamic acid (200 milligrams) and nicotinic acid (200 milligrams) were given daily in divided doses. Her immediate condition was very grave. Shortly after entering the hospital the temperature rose to 101.4 F., the tachycardia persisted and the respirations became Cheyne–Stokes in type. Peculiar convulsive attacks characterized by pallor, ocular spasm, muscular rigidity and fine fibrillary muscular twitchings were noted. These persisted for one or two minutes and were followed by a flushing of the skin and profuse perspiration. Incontinence of urine and feces was present. Spontaneous premature labor followed, the fetal heart sounds disappearing very early in labor. A stillborn macerated fetus was delivered during her second hospital day. Her condition remained grave for several days but was followed by slow improvement. Alternate liquid and dry feedings were begun on the fifth day, this soon was supplemented by a general diet high in vitamins and proteins. The mental confusion was improved by the fifth day and by the tenth day she was mentally clear. Incontinence persisted for two weeks. The electrocardiogram and later the orthodiagram of the heart showed overactivity, tachycardia, very low T waves, low QRS_1, and small Q_2 and Q_3.

Postmortem examination of the infant revealed widespread hemorrhage over the brain and smaller hemorrhages in the pericardium, pleura and thymus.

The patient remained in bed until the tachycardia slowed to 100 and her strength had returned. Weight gain was thirty pounds in forty-five days. Complete reexamination six months after delivery found her to be in good general condition. An electrocardiogram showed rather marked improvement, especially in the T waves. Complete laboratory studies were within normal limits.

This patient had a low vitamin intake and persistent emesis for a long period of time. When coupled with fever over a long period of time, the resulting vitamin deficiency is marked. The acidosis was probably also a combination of starvation and of vitamin B deficiency with tendency to acidosis. The relatively slight trauma of early labor to the fetus with resultant widespread hemorrhage speaks for a hemorrhagic diathesis of the fetus which may be due to vitamin K and C deficiency.

Discussion

Since 1920 high carbohydrate feedings, both oral and parenteral, have been advocated primarily on the basis of glycogen need of the liver, the protection of the liver, the prevention of acidosis and, to a limited extent, the prevention of starvation. Prior to that time treatment of severe hyperemesis gravidarum was self-limited—the patient improved fairly readily, or the pregnancy was spontaneously or artificially terminated, or the patient died. With the introduction of glucose solutions for intravenous injection during the years of 1917–1918, it was not long until their use became common in treatment of hyperemesis, as first advised by Titus and others.[1] This single factor was of great importance in the advancement of the treatment of pernicious vomiting but, as so frequently happens in medicine, this new advancement carried with it new complications. Severe hyperemesis, heretofore a self-limited disease, could now be treated over longer periods of time and patients could be sustained on little more than parenteral

glucose and fluids. As early as 1933 Plass and Mengert[2] recognized the fact that high carbohydrate diets and the presence of emesis were responsible for a vitamin B deficiency which was associated with gestational polyneuritis. The tremendous advancement of our knowledge of vitamins has not only confirmed previous work but also has shown that pellagra and beri beri are not uncommon deficiency diseases. It is logical that symptoms of one or more of these deficiency diseases should be seen in prolonged hyperemesis gravidarum.

Recognizing the danger of overemphasizing a subject in such a state of flux as the vitamins, we must nevertheless realize that most of these patients who have been vomiting for six to twenty-eight weeks have varying degrees of avitaminosis. The most common form of vitamin B deficiency is probably that of gestational polyneuritis; less common are those which show the pellagrinous and beri beri elements such as the last case discussed herein. The peculiar convulsive seizures, definitely not eclamptic or due to alkalosis, have been suggested to be due to the increase in pyruvic acid because of the thiamin deficiency.[3]

There has been a tendency to neglect the parenteral use of vitamins B and C during the period of treatment when little or no food is given by mouth. In addition, it has been definitely demonstrated in animals and suggested in man that large amounts of glucose given to a vitamin B deficient subject cause an immediate exaggeration or precipitation of the deficiency symptoms. Parenteral vitamin therapy is essential until such time as the patient is able to retain oral medication. If the synthetic isolated forms of vitamin B are used, all of the common ones should be given; namely, thiamin, nicotinic acid and riboflavin. The complete vitamin B complex may be given also. Vitamin C should also be given parenterally—the other vitamins may be withheld until well tolerated by mouth.

Proteins are needed and should be supplied as soon as possible. Both of the patients, described herein, demonstrated low serum albumin. Albumin in the form of eggnogs or albumin water can be tolerated early and gives surprising quantities of protein. Judgment will denote the rapidity with which full feedings can be resumed.

In the past certain findings have been used to indicate the necessity of interruption of pregnancy. Some of these are: fever, persistent tachycardia, retinal hemorrhages, lack of clinical improvement, jaundice, mental symptoms such as stupor, confusion and irrationality, fecal and urinary incontinence and others. Many of these are directly the result of the deficiency disease and can be remedied by proper therapy. Jaundice is one of the gravest prognostic signs and unless the patient is rapidly improving, pregnancy should probably be terminated. A word of caution is necessary; many have noted the fact that many patients do poorly in spite of termination and consequently early therapeutic abortions have been advised. If the fundamental disease of severe avitaminosis is present, then termination of the pregnancy will have little to do with it and the patient will be subjected to an operative procedure which will act as a further insult to the body.

A discussion of this type must not be closed without a word about prophylaxis. Rarely is there a case of the milder types of hyperemesis gravidarum that will not respond to planned, thorough, conservative treatment.

Summary

Two cases of grave hyperemesis gravidarum are described.

Prolonged hyperemesis gravidarum can and is frequently accompanied by varying types of vitamin deficiency. Adequate dosage of vitamins, notably vitamins B and C must be given; especially is this true when large amounts of carbohydrates are given. Therapeutic abortion per se does not treat the fundamental deficiency and should be used judiciously and with definite indications.

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Karaya and Related Gums as Causes of Atopy*

By SAMUEL M. FEINBERG, M. D., and BERT B. SCHOENKERMAN, M. D.
Chicago *Milwaukee*

A CASE of perennial vasomotor rhinitis caused by karaya gum was reported in 1934 by Bullen.[1] Shortly after Feinberg[2] reported the history of a beauty operator who had asthma as a result of exposure to the same gum contained in the hair-fixing fluid employed by her in her daily work. As far as we are able to ascertain, these are the first recorded cases of allergy to this material. Since that time we have been using karaya gum as an allergen in routine testing and have recently added other commercial gums, such as acacia and tragacanth. We have felt that, as a result of the extent and variety of uses of these substances, other individuals would probably be found allergic to them.

Acacia, karaya gum and tragacanth are similar substances and are all used for similar purposes, such as a binder, demulcent, adhesive and laxative. They are all obtained from trees or shrubs grown chiefly in India and Asia Minor.

Karaya Gum

In addition to the individual cases of karaya gum allergy reported by Bullen[1] and Feinberg,[2] several similar cases have been described by Figley[3] in the letters of the International Correspondence Club of Allergy. In another communication, in the same series of letters, Bullen[4] calls attention to the fact that "Sterculia gum" is another name for karaya gum. Still more recently, Bowen[5] reported five cases of urticaria due to this allergen. One of these, described in detail, was that of a young woman whose respiratory allergy was found to be caused by a dental plate adhesive powder.

Karaya gum (Indian tragacanth, Sterculia gum) is obtained from *Sterculia urens*. It occurs in irregular, striated, often vermiform, whitish or pinkish brown pieces, occasionally with small fragments of bark attached. It has a distinct acid odor.

We have seen a number of allergic patients in whom karaya gum has given positive skin reactions by the scratch method. In ten patients in this group, it has been definitely shown that part or all of their symptoms were attributable to this allergen. A glance at Table 1 will bring out some of the pertinent facts.

All of the ten patients were women and none were children. In eight the source of exposure was mainly the hair-setting fluid or powder used in their own hair; one was a hair dresser and another apparently had as her source of contact the women visiting her shop after having their hair "done" in a nearby beauty establishment. Of these ten patients, eight were tested with acacia; only one was found to have a positive reaction and that was slight. Nine were tested with tragacanth; two showed slightly positive reactions. In four karaya gum was the sole cause of the allergic symptoms; in the others, additional causes played a part, particularly pollen and fungi.

The character of the allergic symptoms of this group is worthy of note. In three the manifestations were entirely those of rhinitis; in six asthma was the predominant symptom although rhinitis was also present in some of the latter. In one of those with asthma (case 8) a dermatitis of the face and scalp was also attributable to the gum. In one instance (case 3) a dermatitis of the face and neck was the sole complaint. It must be emphasized that although the dermatitis was caused by contact it was, nevertheless, of the atopic variety, as indicated by the presence of the positive scratch test and of circulating reagins. In eight of these ten patients a complete cure, or subsidence of symptoms due to this allergen, was effected by substitution of other ingredients in the preparations employed for the hair. In one (case 2) desensitization was employed with only partial results. In another (case 8) lack of cooperation and the presence of complicating allergy resulted in failure.

* From the department of medicine, Northwestern University Medical School.

The authors previously mentioned have compiled lists of preparations containing karaya gum. Denture adhesives such as Dr. Wernet's powder, Dent–A–firm and Stix, and tooth pastes such as Listerine and Lactona, are listed by Figley[3] as containing karaya gum. Many remedies for constipation are listed by Bowen[5] as containing this gum, among which may be mentioned Saraka, Kara jel, Karaba, Imbicoll, Bassoran, Mucara and Karabim. He also states that karaya gum is found in gum drops, ice cream, prepared ice cream powder, certain brands of gelatin and junket (Knox brand being free from karaya), some candies with soft centers, some diabetic foods including soy bean and almond wafers, emulsified mineral oils and laxatives, fillers for factory-made pies, commercially prepared ices and flavor emulsions, and some salad dressings. Many hair-waving fluids and hand lotions contain karaya gum as their basic ingredient.

Acacia

Acacia, or gum arabic, is described as the dried gummy exudation from the stems and branches of Acacia senegal or some other species of acacia. Unground acacia occurs as large spheroidal tears, white to amber in color, translucent and brittle. The powdered form is made up of angular microscopic fragments with slight traces of starch.

In 1932, Maytum and Magath[6] reported a reaction consisting of rhinitis and dyspnea following an intravenous infusion of acacia. In the same individual a similar injection of acacia six months previously had produced no ill effects. In subsequent experimental work these authors were able to sensitize guinea pigs to this gum but failed to produce sensitization in rabbits.

Three occurrences of severe reaction to the intravenous injection of acacia were reported by Studdiford.[7] The infusions were given for postpartum hemorrhage and were followed shortly by severe and fatal reactions in two cases. The reason suggested for the reaction was either a sensitivity to acacia or the presence of an impurity in the solution.

Acacia was also found, by Spielman and Baldwin,[8] to be the cause of asthma in a candy worker. This patient was shown to be sensitive to the factory dust which was made up chiefly of acacia. Both the dust and the pure acacia gave strongly positive skin re-

TABLE 1.—*Synopsis of 10 Cases of Karaya Gum Sensitivity*

Case	Sex	Age Years	Symptoms	Reaction to tests			Other Allergy	Source of Contact	Course and Results
				Karaya gum	Acacia	Tragacanth			
1. F. S.	F	31	Rhinitis and Asthma	++++	o	o	Tobacco and Orris	Hair-setting fluid (hair dresser)	Change of preparations; cure.
2. S. K.	F	59	Asthma	+++			o	Customers coming from beauty shop.	Desensitization; moderate improvement.
3. M. L.	F	18	Dermatitis of face and neck	++++	o	o	o	Hair-setting fluid	Changed to acacia; cure.
4. S. C.	F	56	Rhinitis	++++		+	o	Proprietary powder for fixing hair	Changed to flaxseed; cure.
5. M. W.	F	19	Rhinitis and seasonal hay fever	++	o	o	Ragweed	Hair-setting fluid	Change of fluid; cure.
6. M. V.	F	29	Rhinitis and seasonal hay fever	++++	o	o	Ragweed	Hair-setting fluid	Change of fluid; cure.
7. O. M.	F	58	Asthma and rhinitis	+++	o	o	Ragweed and fungi, foods	Hair-setting fluid	Changed to tragacanth; rhinitis improved.
8. R. S.	F	22	Asthma, dermatitis of face and scalp	++	o	o	Fungi, foods, epidermals	Hair-setting fluid	Complicating allergy and lack of cooperation by patient; no results.
9. A. F.	F	31	Rhinitis and asthma	+++	o	o	o	Hair-setting fluid	Change of fluid; cure.
10. C. S.	F	43	Rhinitis and asthma	++++	+	+	o	Hair-setting fluid	Elimination of fluid; relieved.

actions. Passive transfer also gave a positive reaction to this material.

We have encountered two patients in whose complaints we feel allergy to acacia played a prominent role. One of them, a 45 year old man, having asthma for a year, attributed his symptoms to a drying spray employed at his occupation of printing. He showed positive reactions to acacia and karaya gum. Investigation of the spraying material disclosed the fact that it contained acacia. Desensitization with acacia was begun, but the results have not been ascertained as yet. The other patient was a 56 year old furniture dealer from Iowa, who had had asthma at intervals since the age of 17 years. Although his history indicated infection as the most likely etiologic factor, complete skin tests showed a marked reaction to acacia. In looking for a source of exposure to this material it was ascertained that some furniture preparations contain this substance. Desensitization treatment with acacia was begun and continued over several months. It is now more than seven months since there has been any evidence of asthma.

As sources of acacia one must look to hand lotions, hair waving fluids, drying sprays, candy and to products of the type in which karaya gum is used.

Tragacanth

Although we are fully aware that partial case reports and incidental mention of cases may be tucked away in articles without coming to one's attention, an intensive survey of the literature has failed to reveal an incrimination of tragacanth as the excitant of allergic manifestations. Because of its close relation to karaya gum we have used it in routine testing and have recently found several positive reactions.

Tragacanth is the dried gummy exudation from *Astragalus gummifer Labellardiere* or other Asiatic species of astragalus. Unground it exists as flat, laminated, fragments of white to light brown color, translucent and horny. Powdered tragacanth shows white angular fragments with circular lamellae and a few starch grains, many of them swollen and altered. This gum is used for practically the same purposes as karaya gum and acacia.

Although we have encountered several mildly positive skin reactions to tragacanth we have seen only one patient in whom we feel certain that tragacanth was a causative factor, a 27 year old woman who complained of urticaria occurring in violent attacks periodically for a period of six years. During the same period she also had an eczematous dermatitis of her hands and fingers. The dermatitis would improve while on vacation. In addition to some reactions to pollen and fungi she showed a decisive reaction to tragacanth. It was ascertained that the hand lotion she used contained this gum. In spite of the fact that precautions for the avoidance of hair-setting fluids and other sources of tragacanth were outlined the patient wrote that she had had another attack of urticaria. We believe that this lack of result is probably a reflection of the wide extent to which this substance is used and our incomplete knowledge of the places where it may be found.

Comment

It should be mentioned that the diagnostic reaction in each of the cases herein described was obtained by the scratch method with the dry powdered gum moistened at the time of making the scratch. In all, except two or three cases, tests with the original material to which the individual was exposed were used to corroborate the diagnosis. Reagins were demonstrated by passive transfer in every one of several cases in which it was tried. Antigenic relationship between these gums has not been worked out, although the results of the skin tests do not suggest any common antigen.

It is evident that in the majority of instances described herein hair-setting materials were the source of the allergen. In most of the cases substitution of a nonreacting gum was adequate to clear the symptoms.

Someone has spread an impression that active solutions of these gums cannot be made for intradermal testing or treatment purposes. This is not true, since we have had potent solutions of all of these. In pre-

(Continued on page 786)

Comments on Treatment

EDITORS
A. J. Quick M. D., Marquette University, Milwaukee
and
M. H. Seevers, M. D., University of Wisconsin, Madison

Establishing Drug Dosage

Numerous rules have been devised for the calculation of dosages of drugs. A majority are based upon the normal variations of age or body weight. While these rules are simple and easy to apply, the exceptions to their accuracy are so numerous as to require a special feat of memory. Attempts to apply other general rules to the exceptions have not met with much success. It is commonly stated, for example, that individuals in both extremes of life—infancy and old age—are especially susceptible to most drugs. Adherents to this view, point out the obvious truth that even if this rule does not apply accurately, a dose too small can be increased, but a dose too large may be irremediable.

Unfortunately, thoughtless application of this philosophy may lead to inadequate therapy in children, since it is now fairly well established that infants and children in proportion to their body weight are more tolerant to many drugs than adults, except possibly during the early days or weeks of life.

Certain examples are worth mentioning. The dosage of antiluetic drugs is commonly larger for children than for adults in proportion to weight. The child may be given 15 mg. of neoarsphenamine per kilogram after preliminary small control doses, while the corresponding dose for adults is only about 9 mg. per kilogram (dose of 0.6 gm.). In pyloric stenosis, infants of two to four weeks are known to tolerate total daily doses of 1.5 mg. of atropine. The limit of tolerance in the adult is around 7 to 9 mg. On a basis of weight, the tolerance of the infant for this drug is two to three times as great. It is now well established that the average digitalizing dose of leaf is greater for children in proportion to their weight than for adults, and that the average daily maintenance dose is greater not only in proportion to weight but in absolute values.

In addition to these examples, it is established clinically that other drugs—barbiturates, quinine, bismuth, sulfanilamide, some mercurials, mandelic acid, epinephrine—are very much better tolerated by children than adults.

On the other hand, there are certain drugs to which children are more highly susceptible. Strychnine is probably the best example, death having been reported from a dose of 3 mg. in a three year old. Infants of six months or less are said to tolerate opium derivatives poorly, although this reputed intolerance does not hold for children of all ages.

Efforts to explain the variable response to different drugs have involved attempts to establish correlations between levels of metabolism, liver and kidney function in relation to age and weight.

Undoubtedly the level of total metabolism as it varies during life affects the response to drugs in some manner, but at present an absolute correlation cannot be made.

The greater tolerance of children for drugs which are partially conjugated or destroyed in the liver, such as quinine or the short-acting barbiturates, or to arsenic which is eliminated through the bile, may possibly be explained on the disproportionate growth of the liver of children in relation to total body weight.

Similarly, an explanation of the tolerance of older infants and children for those drugs which are excreted primarily by the kidney, such as phenobarbital, bismuth, mercury, atropine, mandelic acid and sulfanilamide, may be found in the established high average ratio of urinary output to body weight at these ages.

Dawson sums up the essence of this discussion when he states, "the only principle of dosage that survives is that the dose must be adjusted to the individual patient, and that nothing can or will supersede clinical experience, and careful study, combined with good judgment." M. H. S.

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« « « EDITORIALS » » »

Ninety-Ninth Anniversary Meeting

FOR several years the State Medical Society of Wisconsin has led societies of comparable size in the percentage of its members that attend its annual sessions. Last year this percentage exceeded one out of every two physicians in the entire State. An even larger attendance is anticipated at the sessions in Milwaukee on September 18, 19, and 20.

A program in the field of graduate education,—that is what the annual meeting sets out to accomplish,—to be of greatest value must be timely in the sense that it deals with subject matter of present or growing importance to the physicians who attend. At a time when the Wisconsin Industrial Commission has just approved a plan of preemployment and employment examinations in industry, surely nothing could be more timely than the planned program dealing with industrial medicine and the accompanying 1,700 square feet of scientific exhibits covering this same field, together constituting a feature of this coming annual meeting. Secondly, the problems of medicine and of each individual physician in this day of rapidly expanding military preparedness are likewise extremely timely. This entire field in its major implications will be covered on the Friday afternoon program.

To be successful a program of graduate education must not only be timely but it must deal in terms of the problems as faced by the great majority of physicians who will attend. Throughout the program including the thirty-five round-table luncheons, this underlying thought is constantly in evidence.

The ninety-ninth anniversary meeting of the Society is one that brings to the membership information that will repay attendance. Your friends will be there and will look for you.

. . . . THE PRESIDENT'S PAGE . . . .

THIS is my last *President's Page.* When I took the presidency a year ago I had considerable doubt in my mind and misgiving as to the wisdom of my selection. The profession of medicine has been good to me and I owe it much, so much that I was apprehensive lest I not fulfill the office to the best interests of medicine. The ship of medicine has been in a violent gale the past few years and only the sagacity and wisdom of its officers for the past twenty-five years have kept it afloat, not only in Wisconsin, but over the entire United States. Therefore one feels humble in assuming such an office.

The British navy a couple of centuries ago lost considerable of its rope through theft and so to insure it and to vouchsafe its quality the admiralty had one blue strand of hemp woven through it. In medicine this blue strand of hemp represents the lives of men, some living and many dead—officers of societies, trustees of the American Medical Association, professors in medical schools—who in the past gave something of their lives to make the profession of medicine great. These men put something into medicine that went beyond the printed code of ethics; it was a standard of practice, it was the patients' rights, it was a standard for advancement in science, it was a standard in public health and the treatment of the mentally incompetent. It was the Magna Carta of medicine. And, above all, this profession of ours organized men into county medical societies, then into state societies and these collected together made up the American Medical Association, the equivalent of which the world has never seen. Through the past few years this profession of ours has been attacked by dreamers and Don Quixotes, men and women with a strange mission, so strange that they themselves knew very little about it, but through it all they had a vague idea of making us all wear red neckties. The foundation of medicine, however, was so strong, founded in precept and in fact, that to date we still carry on as free men, with science still unhindered even if we presently face a Federal court to answer the charge of close organization, organization which is the envy of every other profession in America.

Those practicing medicine are not in themselves paragon by any means. This is naturally so because they are men and women, possessed of all our good and bad traits.

About a year ago I addressed the student body of the Marquette School of Medicine* and there stated that I deplored the fast disappearance of the art of medicine with all of its attributes, which so endeared it to the public, and that the science of medicine was fast closing the art out. Science is a cold thing; there is nothing friendly about it and as we have increased in it by leaps and bounds we have weaned ourselves away from our patients, the public. The friendly hand of the family counselor upon the shoulder of the patient is gone. A man, when he is well, delights in reading in the newspaper about new scientific discoveries but when he is bedridden today he finds himself in a daze. What with all the tests, white-coated interns, nurses, etc., he no longer cares for new and greater discoveries but he wants his own personal doctor to sit down with him for a few minutes and tell him something about his trouble. I was prompted to write on this subject again today because of a conversation I had last evening with a very fine, elderly lady who was the superintendent of an old peoples' home. She had had some illness and had been under the care of an eminent internist who had hospitalized her. All the tests had been taken, but, she said, "My doctor never examined me himself; he left it all for the rest of them to do." It seems to be common practice for doctors to hospitalize the patient and perhaps operate upon them; after that the whole plan of treatment falls to the intern or the resident, and yet the physician knows full well that these men are in the hospital only for the purpose of study.

I have never failed to listen carefully in my corner to the complaint of the public and I can truly say that there are many complaints today relative to hospital practice. If the

* Address published in THE JOURNAL, April, 1940.

intern and resident are going to take over the work of the physician, why isn't it natural for the hospital superintendent to do some figuring and propose to his board that the hospital set itself up as a dispenser of medical service? This thought has become somewhat vocal of late.

I have sat in on many hospital staff meetings; some are good and some otherwise. The function of a hospital staff, as I understand it, concerns not only its operative work of the day but also the hospital and medicine in the future. The physician attending a modern hospital has seen the day come when he is in truth an attendant and has seen the hospital that his forefathers in medicine founded, organize and move away and above him. One of the great functions that the member of a staff can still perform is to reach out and take back some of the prerogatives that were his and so state his position that the heads of well meaning hospitals will not be led astray by a national socialistic influence that seems to be pervading everything these days. The spines of hospital staffs must be stiffened. The strength of a united profession must at all times be exerted against any movements that would wrest from us, for their selfish gain, any of the long-fought-for ideals of medical practice.

This is not the time or the place for me to go into the faults and ills of medicine but I have spent time and energy on the problem and I know that other officers of the Society have also, so I am naturally anxious that the individual member plug the dike when he finds an opportunity.

Someday someone will get a headache trying to solve the problem of how to cope with the weekly product of the pharmaceutical houses, even of those in good repute, to say nothing of the little fly-by-nights that are increasing daily. One of the saddest things that I have witnessed in medicine is the handing out of samples in the original packages by the physician. He has not only made the nation a land of aspirin munchers but he has lubricated millions of yards of intestine with mineral oil. Each patient dotes on his particular brand, which he readily calls by name, and advises his neighbors to use. Although sulfanilimide is a drug to be used with caution the general public is pretty well "up" on it, thanks to the publicity of the doctor, and in another year its use will be as common as aspirin. If I were very sick tomorrow I would not be interested in the drugs given but I would be very interested in getting well.

It is the duty of medical schools to give a respectable course in pharmacology, therapeutics and prescription writing. I would not expect to be able to interpret an architect's plans and I know from experience that legal advice as gathered from the curbstone is costly. But all this is surpassed in the country a millionfold by the handing out of samples with literature enclosed for the treatment of almost everything.

The profession of medicine is a great institution; it forms a great part of everyday life. Flesh is heir to disease and accident, so the physician must of necessity accompany industry, exploration, armies and the home. Let's keep its ideals as high as they ever were and strive to make them come truer to our wishful thinking. Let's maintain the discipline over ourselves that we have in the past; let's teach students to be great doctors and teach them their duty and their responsibility to the sick man as an individual. In a day when the world is mad, stand out as educated men and give assurance to troubled people, for we as physicians know a little, at least, about the workings of the human mind.

If we do this, and do it well, some day some historian will say that in a time of strife and world revolution of thought, the physician stood out in relief as the great healer of body and mind.

Love the little trade which thou hast learned, and be content therewith.
—The reflections of MARCUS AURELIUS.

R. G. Arum

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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Final Plans For Twelfth Annual Meeting of Auxiliary Are Announced

A LARGE attendance is expected for the twelfth annual meeting of the Woman's Auxiliary to the State Medical Society to be held in Milwaukee, September 17, 18, and 19. Assisting the Woman's Auxiliary to the Medical Society of Milwaukee County in the arrangements are the members of the Winnebago County Auxiliary.

We are to be honored with the presence of the national president, Mrs. V. E. Holcombe of Charleston, West Virginia, who will address the members at the business meeting on Thursday, September 19. This business session, as well as the meetings on Wednesday and Thursday mornings, will be held in the Club Rooms of the Schroeder Hotel.

At the Wednesday luncheon in the Crystal Ballroom, Hotel Schroeder, Reverend Raphael C. McCarthy, S. J., president of Marquette University, will speak on the topic "The Role of Fear in Human Behavior." Dr. R. G. Arveson of Frederic, retiring president of the State Medical Society, will be guest of honor and bring a message of interest. This interesting program will be followed by bridge.

Wednesday evening will be a gala event, the Mexican Fiesta with the "Singers of Valencia" furnishing the entertainment. Thursday noon the luncheon "News and Fashions" will be held in the Crystal Ball-

—Photograph by Stein, Milwaukee.

Mrs. Eben J. Carey, Milwaukee, Convention Chairman, State Auxiliary.

room. A well-known news commentator, Phil A. Grau, will give thirty minutes of news; this will be followed by a showing of fashions from Stuarts.

Attendance at these events is by ticket only and advance reservations would be greatly appreciated. Every doctor's wife whether or not a member of the Auxiliary is urged to *register early*. The committee in charge of arrangements is endeavoring to make this convention the most enjoyable ever held. Come and meet your friends and make new acquaintances.

The annual dinner for the physicians and their wives will be held on Thursday evening in the Crystal Ballroom of the Schroeder Hotel. The speaker will be Dr. Eben J. Carey, dean of Marquette University School of Medicine, and his topic will be "Democracy and the Doctor."

Final Program of Auxiliary

Tuesday, September 17, 1940

P. M.

2:00–4:30 Registration—Hotel Schroeder

7:00 Board of Directors' Dinner—University Club
Mrs. Frank W. Pope, president, presiding
Reports of State Auxiliary Chairmen

Wednesday, September 18, 1940

A. M.

10:00 General Meeting—Club Rooms, Third Floor, Hotel Schroeder
Mrs. Frank W. Pope, president, presiding
Invocation—Reverend E. S. Hjortland, pastor, Ascension Lutheran Church
Convention Announcements — Mrs. Eben J. Carey, chairman
"Greetings,"—The Hon. Carl F. Zeidler, Mayor of the City of Milwaukee
Address of Welcome—Mrs. C. D. Partridge, president, Woman's Auxiliary to the Medical Society of Milwaukee County
Response—Mrs. W. Homer Krehl, president, Woman's Auxiliary to the Dane County Medical Society
In Memoriam
Reports of State Officers and County Auxiliary Presidents
Report of Chairman, Committee on Credentials and Registration
Announcements

P. M.

1:00 Luncheon and Bridge — Crystal Ballroom, Hotel Schroeder
"The Role of Fear in Human Behavior" — Speaker, Reverend Raphael C. McCarthy, S. J., president, Marquette University
Assisting Hostesses—Members of the Woman's Auxiliary to the Winnebago County Medical Society
Mrs. F. Gregory Connell, Oshkosh, Chairman
Mrs. Earl B. Williams, Oshkosh, Co-Chairman
Tickets $1.25

P. M.

8:30 Fiesta — Banquet Room, Fifth Floor, Hotel Schroeder
Entertainment—"Singers of Valencia" (Mrs. Lorna Warfield, director)
Refreshments

Mrs. Frank W. Pope, Racine, President State Auxiliary.

Thursday, September 19, 1940

A. M.

9:30 General Meeting—Club Rooms, Third Floor, Hotel Schroeder

Mrs. Frank W. Pope, president, presiding

Address — Mrs. V. E. Holcombe, president, Woman's Auxiliary to the American Medical Association

Business Session and Election of Officers

Induction of the President, Mrs. Donne F. Gosin, Green Bay

Installation of New Officers

Announcements

Adjournment

11:30 Post-Convention Meeting of Board of Directors — Club Rooms, Third Floor, Hotel Schroeder

Mrs. Donne F. Gosin, president, presiding

P. M.

1:00 Luncheon, "News and Fashions" — Crystal Ballroom, Hotel Schroeder

News—Phil A. Grau, commentator
Fashions by Stuarts. Tickets $1.25.

6:45 Annual Dinner — Crystal Ballroom, Hotel Schroeder. Tickets $2.

Mrs. V. E. Holcombe, Charleston, West Virginia; president, Woman's Auxiliary, American Medical Association.

Annual Meeting Committees

Annual Meeting

Mrs. Eben J. Carey, Chairman
Mrs. Charles Fidler, Co-Chairman
Mrs. Harry J. Heeb, Co-Chairman

Headquarters

Mrs. Richard D. Champney, Chairman
Mrs. George H. Hoffman, Co-Chairman
Mrs. Salvatore Megna

Hostesses

Mrs. Robert E. McDonald, Chairman
Mrs. Enoch F. Peterson, Co-Chairman
Mrs. William M. Jermain, Co-Chairman
Mrs. Carroll D. Partridge
Mrs. Ralph D. Bergen
Mrs. Charles Fidler
Mrs. Rudolph C. Pfeil
Mrs. William H. Studley
Mrs. William C. Liefert
Mrs. William F. Grotjan
Mrs. Harold J. Cannon
Mrs. Gerald H. Friedman
Mrs. Valorus F. Lang
Mrs. Richard D. Champney
Mrs. William B. Ford
Mrs. Robert E. Fitzgerald
Mrs. Rock Sleyster
Mrs. J. Gurney Taylor
Mrs. James C. Sargent
Mrs. Thornton M. Northey
Mrs. John J. McGovern
Mrs. John McCabe
Mrs. Robert G. Washburn
Mrs. Arno R. Langjahr
Mrs. Thomas A. Judge
Mrs. Joseph J. Lettenberger
Mrs. Edward M. Lawler
Mrs. Edwin P. Bickler

Hostesses—Bridge Party

Members of Woman's Auxiliary to the Winnebago County Medical Society
Mrs. F. Gregory Connell, Oshkosh, Chairman
Mrs. Earl B. Williams, Oshkosh, Co-Chairman

Registration and Credentials

Mrs. Oscar W. Friske, Beloit, Chairman
Mrs. Raymond P. Schowalter, Co-Chairman
Mrs. Francis R. Janney
Mrs. Irwin Schulz

Reservation and Tickets

Mrs. Charles Fidler, Chairman
Mrs. Edward F. Barta, Co-Chairman
Mrs. Paul M. Currer
Mrs. Edward M. Lawler
Mrs. William A. Ryan
Mrs. Charles M. Schoen

Publicity

Mrs. Jerome M. Jekel, Chairman
Mrs. James O. Kelley, Co-Chairman

Information, Convention Hall

Mrs. William J. Scollard, Chairman
Mrs. Edward J. Schelble, Co-Chairman
Mrs. Michael J. Kuhn
Mrs. John P. Fetherston
Mrs. Peter E. Oberbreckling
Mrs. Frank Rettig
Mrs. Frank J. Kozina
Mrs. Clarence F. McDonald
Mrs. Armond J. Ruppenthal

Information, Hotel Schroeder

Mrs. William F. Grotjan, Chairman
Mrs. George J. Pugh, Co-Chairman
Mrs. Charles J. Becker
Mrs. Edgar J. Behnke
Mrs. Gerald H. Friedman
Mrs. Ralph W. Garens
Mrs. Anthony S. Kult
Mrs. Rudolph P. Gingrass
Mrs. Herbert W. Powers
Mrs. Robert W. Blumenthal

Flowers

Mrs. Valorus F. Lang, Chairman
Mrs. Ralph P. Sproule, Co-Chairman
Mrs. Millard Tufts, Co-Chairman
Mrs. Robert H. Feldt
Mrs. Merle Q. Howard
Mrs. Silvanus A. Morton
Mrs. Joseph J. Gramling, Jr.
Mrs. H. K. B. Allebach

Pages

Mrs. N. Warren Bourne, Chairman
Mrs. William P. O'Malley
Mrs. Bernard P. Churchill
Mrs. John Huston
Mrs. Norbert Enzer
Mrs. Frederick C. Heidner
Mrs. Maurice A. Hardgrove

Style Show

Mrs. Harold J. Cannon, Chairman
Mrs. Ralph D. Bergen, Co-Chairman

COUNTY AUXILIARY NEWS

Manitowoc

While the physicians of the fifth district of the State Medical Society of Wisconsin were busy with scientific and technical discussions on the afternoon of June 27, their wives were entertained by the members of the Woman's Auxiliary to the Manitowoc County Medical Society with a tour of the city, bridge, and tea. About fifty-five women were present.

The tour took them to the Aluminum Goods Mfg. Co., where they received souvenirs; Kingsbury Brewery, where they were served refreshments; Schuette's Park, Lincoln Park, and the Manitowoc Shipbuilding Co. Those who preferred bridge played at the Catholic Center while the others went on the tour.

In the evening the women joined their husbands at a banquet at the Catholic Center. Speakers were Dr. R. G. Arveson of Frederic, president of the State Medical Society of Wisconsin, and Dr. Eben J. Carey of Milwaukee, dean of Marquette University School of Medicine.

Waupaca—Shawano

The members of the Woman's Auxiliary to the Waupaca–Shawano County Medical Society met for a one o'clock luncheon in Clintonville on August 6, at the Marson Hotel. The hostesses were Mrs. J. H. Murphy, Mrs. E. A. Miller, Mrs. W. H. Finney, Clintonville; Mrs. F. M. Mulvaney and Mrs. R. E. Van Schaick of Marion. Twelve members and three guests were present, all being seated at a long table with floral decorations in yellow and blue.

After the luncheon Miss Chambers, the county nurse and guest of honor, gave a brief talk on the kind of work county nurses are doing. She operated a moving picture machine showing two instructive sound movies on child health and tuberculosis.

The business meeting was held at the home of Mrs. W. H. Finney, press and publicity chairman. The president, Mrs. W. J. Irvine, presided. Various committee reports were given, and the treasurer, Mrs. Mulvaney, reported that the dues had been paid 100 per cent. Chairman of public relations, Mrs. E. A. Miller, reported having contacted the Women's Club of Clintonville for an open date in their program for the coming year and a speaker to be provided by the auxiliary. The names of two Clintonville women, Mrs. C. A. Topp and Mrs. R. F. Braun, were presented, and they will become new members at the November meeting.

Mrs. W. J. Irvine, who attended the national convention in New York in June, gave the members an interesting report. At the close of the meeting, light refreshments were served, and the members enjoyed a social visit.

REGISTER EARLY!

All Auxiliary members are urged to register at the registration desk in the Schroeder Hotel lobby as soon as possible after arrival in Milwaukee. If Milwaukee members will register on Tuesday afternoon, it will be greatly appreciated by the committee in charge.

Delegates and Alternate Delegates to the Twelfth Annual Meeting of Women's Auxiliary to State Medical Society of Wisconsin

County	*President or Delegate*	*Alternate Delegate*
Brown–Kewaunee–Door	Mrs. M. H. Fuller	Mrs. E. S. Knox
	Mrs. L. D. Quigley	Mrs. E. G. Nadeau
Columbia–Marquette–Adams	Mrs. L. V. McNamara	Mrs. C. J. Radl
	Mrs. J. W. MacGregor	Mrs. H. E. Gillette
Dane	Mrs. W. H. Krehl	Mrs. H. A. Keenan
	Mrs. H. W. Virgin	Mrs. P. A. Duehr
	Mrs. D. L. Williams	Mrs. T. W. Tormey
	Mrs. K. K. Amundson	Mrs. F. K. Dean
Dodge	Mrs. R. R. Roberts	Mrs. A. W. Hammond
	Mrs. W. H. Costello	Mrs. J. M. Welch
Douglas	No report	
Fond du Lac	Mrs. A. M. Hutter	Mrs. W. C. Finn
	Mrs. S. A. Theisen	Mrs. E. V. Smith
Green Lake–Waushara	Mrs. E. S. Sinaiko	Mrs. J. A. Kelly
Kenosha	Mrs. H. L. Schwartz	Mrs. L. H. Lokvam
	Mrs. W. C. Kleinpell	Mrs. C. M. Creswell
La Crosse	Mrs. F. A. Douglas	Mrs. Gunnar Gundersen
	Mrs. J. C. Fox	Mrs. J. J. Simones
Manitowoc	Mrs. T. H. Rees	Mrs. F. W. Hammond
	Mrs. T. A. Teitgen	Mrs. W. E. Donohue
Marinette–Florence	Mrs. J. V. May	
	Mrs. H. L. Jorgenson	
Milwaukee	Mrs. C. D. Partridge	Mrs. R. D. Bergen
	Mrs. R. D. Champney	Mrs. Charles Fidler
	Mrs. R. E. MacDonald	Mrs. R. C. Pfeil
	Mrs. G. H. Friedman	Mrs. W. H. Studley
	Mrs. W. F. Grotjan	Mrs. H. J. Cannon
	Mrs. V. F. Lang	Mrs. W. B. Ford
	Mrs. W. C. Liefert	Mrs. W. M. Jermain
	Mrs. R. E. Fitzgerald	Mrs. M. A. Hardgrove
Oconto	No report	
Outagamie	Mrs. W. S. Marshall	Mrs. C. D. Neidhold
	Mrs. M. E. Swanton	Mrs. G. W. Carlson
Polk	Mrs. A. N. Nelson	Mrs. W. C. Andrews
	Mrs. R. G. Arveson	Mrs. L. A. Campbell
Portage	Mrs. T. L. Harrington	Mrs. A. G. Dunn
	Mrs. W. C. Sheehan	Mrs. S. R. Miller
Racine	Mrs. A. S. Pfeiffer	Mrs. E. W. Schacht
	Mrs. H. B. Keland	Mrs. J. F. Henken
	Mrs. G. N. Gillett	Mrs. C. O. Schaefer
Rock	Mrs. L. J. Friend	Mrs. H. E. Kasten
	Mrs. C. R. Gilbertson	Mrs. W. T. Clark
Sauk	Mrs. C. B. Pope	Mrs. H. A. Bachhuber
	Mrs. A. C. Edwards	Mrs. E. V. Stadel
Sheboygan	Mrs. A. J. Brickbauer	Mrs. J. W. McRoberts
	Mrs. G. J. Hildebrand	Mrs. C. M. Yoran
Trempealeau–Jackson–Buffalo	Mrs. H. A. Jegi	Mrs. I. K. Krohn
	Mrs. R. R. Richards	Mrs. F. C. Skemp
Walworth	Mrs. S. G. Meany	
	Mrs. E. D. Sorenson	
Washington–Ozaukee	Mrs. A. H. Barr	Mrs. O. J. Hurth
	Mrs. A. H. Heidner	Mrs. R. S. Fisher
Waukesha	Mrs. D. C. Wilkinson	Mrs. T. H. Nammacher
	Mrs. O. C. Clark	Mrs. J. C. Frick
Waupaca–Shawano	Mrs. W. J. Irvine	Mrs. E. A. Weller
	Mrs. L. G. Patterson	Mrs. L. W. Peterson
Winnebago	Mrs. F. G. Connell	Mrs. T. D. Smith
Wood	Mrs. R. E. Garrison	Mrs. L. C. Pomainville
	Mrs. W. L. Nelson	Mrs. P. E. Wright

Society Proceedings

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society met with members of the dental profession on August 15 at Rockwood Lodge, fourteen miles north of Green Bay. In the afternoon the doctors enjoyed baseball, swimming, boating and other outdoor recreations. Dinner was served at 7 p. m. and Mr. J. G. Crownhart, secretary of the State Medical Society, addressed the group on "Present Status of Medical and Dental Legislation."

Fond du Lac

The Fond du Lac County Medical Society and their families and friends enjoyed a picnic on August 15. They met at Norton Pier at Green Lake and took a boat trip to Sugar Loaf where the picnic lunch was served.

Pierce—St. Croix

Members of the Pierce–St. Croix County Medical Society were the guests in July of Dr. O. H. Epley at his cottage on Half Moon Lake. The group enjoyed an afternoon out of doors and, in the evening, a picnic supper. Members of the Polk County Medical Society were guests.

Polk

The Polk County Medical Society held its May meeting at the St. Croix Inn in St. Croix Falls. The members were the guests of Dr. H. C. Caldwell at dinner. Dr. A. N. Nelson discussed the work of the society's public relation committee, and a scientific program was presented by members of the society as follows: "Geriatrics," Dr. S. C. Peterson, Luck; "Bactericidal Effect of Sulfathiazole," Dr. E. T. Rechlitz, Milltown; and "Migraine" and "Use of Nitrazine Paper for Testing Urine," Dr. L. O. Simenstad, Osceola.

On June 20 the society met for a "dutch treat" supper at the Ike Walton Lodge on Yellow Lake, and a scientific session featuring lectures by Drs. Edward Evans and S. W. Shimonick, of the University of Minnesota orthopedic staff, on "Backache and Sciatica."

The society and its woman's auxiliary were guests, July 25, of Dr. and Mrs. J. A. Riegel at their summer cottage on Deer Lake. A barbecue steak dinner was served out of doors. Dr. Vernon Smith, St. Paul, showed some colored motion pictures, following the dinner, of wild goose and big game hunting in Canada and duck hunting on Leach Lake, Minnesota. At this meeting, Dr. A. N. Nelson, president of the society, appointed two members to examine the 4H group of boys and girls preliminary to the opening of the Polk county fair.

On August 15 members of the society were the guests of Dr. K. K. Ford, Amery, at a dinner served at the Amery Hotel. A business meeting was held, and two members of the society presented scientific papers as follows: "Inguinal Hernia in Small Infants," Dr. George B. Noyes, Centuria; "Speech Defects," Dr. A. N. Nelson, Clear Lake.

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met on July 18 in the Village Hall, Galesville. Dinner was served to the group at 6 p. m. and then a scientific session was held. Dr. Walter Sexton, Marshfield, discussed "Hematuria" and Dr. Lyman A. Copps, Marshfield, "Eye Disease." Fourteen attended.

The society met at Blair on August 22. Following dinner, served at 6 p.m., a scientific program was presented. Dr. R. S. Baldwin, Marshfield, discussed "The Management of Diabetes," and Dr. Stephan Epstein, Marshfield, "Common Skin Diseases."

Eleventh Councilor District

The *Superior Telegram* carried the following interesting description of the Eleventh Councilor District annual meeting in Superior, August 8.

Official posts of the Eleventh District Medical Society, embracing several counties of Northern Wisconsin, passed from Superior to Ashland Friday, following an election that climaxed the annual meeting of that group here Thursday.

The new leader of the district is Dr. W. J. Tucker of Ashland. He succeeds to the position previously held by Dr. James McGill of Superior. Ashland had a "clean sweep" of the elections when a new secretary was balloted, and Dr. A. H. Lamal succeeded Dr. Conrad Giesen of Superior.

The elections were supplemental, physicians said, to discussions of recent trends in medical research. Principal speaker was Dr. W. J. Heyerdale, of the Mayo Clinic at Rochester. Dr. Heyerdale stepped from the golf course, where he won a tie for the championship with Dr. E. A. Meyers of Superior, to the meeting floor, where he lectured on varicose veins.

Also sharing the lecture platform with Dr. Heyerdale were Drs. E. L. Tuohy and J. R. Manley of Duluth, and Dr. Tucker of Ashland.

Dr. R. G. Arveson of Frederic, president of the state medical society, spoke briefly to the physicians.

See the new Wisconsin Pharmacists' Page in this issue of The Journal, page 787.

News Items and Personals

Dr. R. E. Fitzgerald, Wauwatosa, has been named Wisconsin state chairman of the American Medical Association's Committee on Medical Preparedness. Dr. Fitzgerald is also chairman of the M–Day Committee of the State Medical Society, a special committee recently appointed to act in liaison with proper military and civil authorities to the end that, should M–Day become a reality, there may be an unhurried and effective program both to supply the medical needs of the military and to secure proper medical care at home during the emergency. Other members of the State Society's M–Day Committee are *Dr. J. W. Lambert,* Antigo; *Dr. Robert W. Blumenthal,* Milwaukee; and (ex officio) Mr. J. G. Crownhart, Madison.

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A total of 328 physicians attended the series of ten institutes on chest diseases, presented the first two weeks of August under the joint auspices of the State Medical Society of Wisconsin, the State Board of Health, the Wisconsin Anti-Tuberculosis Association and sanatoria in the State. Included among them were councilors of the State Medical Society as follows: *Drs. W. T. Clark,* Janesville; *H. A. Jegi,* Galesville; *H. H. Christofferson,* Colby; and *F. G. Johnson,* Iron River. At the institute held at Pureair Sanatorium, Bayfield, Dr. Johnson presented a picture, "Stowing the Sail" to Dr. H. M. Hosmer, who has been a leader in tuberculosis activities in Ashland, Bayfield and Iron counties since the inception of the organized fight against tuberculosis in Wisconsin.

Following is a list of the sanatoriums where the institutes were held, with the attendance at each:

Sanatorium	Attendance
Sunny View, Winnebago	14
Rocky Knoll, Plymouth	35
Maple Crest, Whitelaw	18
Hickory Grove, West De Pere	35
Mount View, Wausau	37
Pureair, Bayfield	21
Mt. Washington, Eau Claire	45
Oak Forest, Onalaska	34
Pinehurst, Janesville	36
Sunny Rest, Racine	53

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Dr. Gerald F. Burgardt, has been named deputy health commissioner of Milwaukee by *Dr. E. R. Krumbiegel,* health commissioner, to succeed *Dr. E. V. Brumbaugh,* resigned. Dr. Burgardt was graduated from Marquette University School of Medicine in 1937.

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Dr. Leland C. Pomainville, Wisconsin Rapids, recently addressed his local Kiwanis Club on "Venereal Disease," and "Importance of Wassermann Tests in Pregnancy."

Dr. W. J. Urben, who has been associated with Milwaukee County Hospital for Mental Diseases at Wauwatosa, has been appointed senior physician on the staff of Mendota State Hospital, Mendota.

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Among Madison physicians attending the American Congress of Physical Therapy in Cleveland, September 2–6, was *Dr. James C. Elsom,* professor emeritus of physical therapy, University of Wisconsin Medical School.

—△—

Dr. W. S. Middleton, dean of the University of Wisconsin Medical School, traced the history of medical training in Wisconsin at a meeting of the Janesville Rotary Club, August 5.

—△—

Drs. Ralph P. Sproule and *W. M. Jermain,* Milwaukee, spoke at the opening of the 13th annual meeting of the Polish Medical and Dental Association of America, in Milwaukee, August 15. The aim of the Polish organization is to elevate the professional standards of Poles in America, to distribute health knowledge, and to sponsor Polish culture and ideals.

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Dr. Grant R. Curless left Beloit on August 15 to join the staff of the Battle Creek Sanitarium, Battle Creek, Michigan. His position in the sanitarium is that of consultant in the department of internal medicine.

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Dr. Ronald S. MacKechnie, Hillsboro, was the guest of honor at a picnic on July 17, given by friends from the communities of Mt. Tabor, Burr and Valley in appreciation of his thirty years of service to them. *Dr. Patrick H. Hansberry* of Hillsboro was the master of ceremonies at an afternoon program, which included talks by several physicians from neighboring cities and a brief description by Dr. MacKechnie of the early days of his medical practice. A feature of the program was the music of a fife and drum corps.

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Dr. Chester M. Echols, Milwaukee, discussed "State Medicine" before the Kiwanis Club of Port Washington on July 23.

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Miss Gladys Ramsey, librarian, University of Wisconsin Medical School, reports that the new medical school library of the University of Oregon played host to the 42nd annual meeting of the Medical Library Association in Portland, June 25–27. She states two symposiums were of special interest to medical librarians who do reference work.

In the first symposium "History and Literature of Epidemiology with Emphasis on Some Pacific

Coast Aspects" was discussed by Dr. L. F. Ray, Portland; "Plague" by Dr. H. J. Sears, University of Oregon Medical School; "Tularemia" by Dr. William Levin, Oregon State Board of Health, and "Rocky Mountain Spotted Fever" by Dr. C. B. Philip, federal health officer located in Hamilton, Montana.

In the second symposium Dr. Olof Larsell of the University of Oregon Medical School (formerly on the staff of the University of Wisconsin Medical School) spoke on "Pacific Northwest Medical History." A round table discussion was held on "Methods in Regional Medical Historical Research."

Officers elected for 1940–41 include:

President—Col. Harold W. Jones, Army Medical Library, Washington, D. C.

Vice-president — Dr. Robert E. Schlueter, St. Louis, Missouri.

Secretary—Miss Anna C. Holt, Harvard University Medical School, Boston, Mass.

The Medical Library Association counts among its members 250 medical libraries of the United States, Canada, England, Cuba, Puerto Rico and China. Its greatest service to its membership is the "Exchange" through which duplicate books and journals from all member libraries are listed and distributed at a cost of transportation only. The University of Wisconsin Medical School acquired 149 bound volumes and 1,378 unbound journals from this source in 1939.

Coming Events

International Assembly of the Inter-State Postgraduate Medical Association of North America.—The Assembly will be held in the Public Auditorium, Cleveland, Ohio, October 14–18, and officers of the Inter-State Postgraduate Medical Association, the Academy of Medicine of Cleveland, the Cuyahoga County Medical Society and the Ohio State Medical Association extend a very cordial invitation to all members of the profession in good standing to attend. Attendants are urged to bring their ladies with them as a program is being arranged for their benefit by the Ladies' Committee.

A full program of scientific and clinical sessions will be presented each day and evening of the Assembly, starting at 8 a.m. An excellent opportunity is thus provided for an intensive week of postgraduate medical instruction by some eighty distinguished teachers and clinicians from various sections of the United States and Canada. A list of the speakers and further information concerning the program are given on page 784 of this issue. The registration fee for the scientific and clinical sessions will be $5.

Wisconsin Tuberculosis Society to Meet.—The second meeting of the recently organized Wisconsin Tuberculosis Society will be held at the Wisconsin State Sanatorium, Statesan, September 17, 1940. The meeting will start at 10 a.m. All physicians interested in the newest procedures in the diagnosis and treatment of tuberculosis and other diseases of the lungs are invited to attend.

Those attending the event will be guests of Dr. H. M. Coon, superintendent of the Wisconsin State Sanatorium at a noon luncheon. All planning to attend should write Dr. Coon direct or make reservations either with Dr. W. H. Oatway, Jr., Madison, president of the Wisconsin Tuberculosis Society, or with Dr. A. A. Pleyte, Milwaukee, secretary of the Society.

PROGRAM OF THE WISCONSIN TUBERCULOSIS SOCIETY

Wisconsin State Sanatorium, Statesan, Wisconsin*

September 17, 1940

Dr. W. H. Oatway, Jr., Presiding

A.M.

10:00 Business Session

10:10 *Review of Major Surgical Cases at Mt. View Sanatorium, Wausau*—Dr. H. H. Christensen, Wausau

10:30 Discussion—Dr. Forrester Raine, Milwaukee, and Dr. Carl Schaefer, Racine

10:40 *Paraffin Plombage*—Dr. John Steele, Muirdale Sanatorium, Wauwatosa

11:00 Discussion—Dr. Joseph Gale, Wisconsin General Hospital, Madison

11:05 *The Prognostic Significance of Positive Gastric Aspiration in the Treated Patient*—Dr. George Owen, Sunny View Sanatorium, Winnebago

11:25 Discussion—Dr. H. M. Coon, Wisconsin State Sanatorium and Dr. R. H. Stiehm, University of Wisconsin, Madison

11:35 *Cavity Drainage*—Dr. D. D. Feld, Muirdale Sanatorium, Wauwatosa

11:55 Discussion—Dr. Joseph Gale, Madison

Luncheon—Wisconsin State Sanatorium

P.M.

2:00 *Use of Gas Analysis with Pulmonary Diagnosis*—Dr. Nathan Grossman, Muirdale Sanatorium, Wauwatosa

2:20 Discussion—Dr. A. L. Banyai, Muirdale Sanatorium, Wauwatosa

2:30 *Chemotherapy in Tuberculosis*—Dr. Henry C. Sweany, Municipal Tuberculosis Sanatorium, Chicago, Ill.

3:00 Discussion—Dr. Paul L. Eisele, Wisconsin State Sanatorium

3:05 *X-ray Session*—Cases to be presented by—
Dr. C. M. Yoran, Rocky Knoll Sanatorium, Plymouth
Dr. H. M. Coon, Wisconsin State Sanatorium, Statesan
Dr. Geo. Beebe, Mt. Washington Sanatorium, Eau Claire
Dr. Chas. Ulrich, Willowbrook Sanatorium, Kenosha
Dr. Nathan Grossman, Muirdale Sanatorium, Wauwatosa

* ½ mile north of junction of U.S. Highway 18 and State Highway 83.

OFFICIAL NOTICE OF PROPOSED CHANGE IN CONSTITUTION

The following proposed amendment to Section 2, Article IX of the Constitution of the State Medical Society of Wisconsin—submitted at the 1939 session of the House of Delegates of the State Society by the Jefferson County Medical Society through Dr. W. S. Waite of Watertown, delegate—will be voted on by the House at its September 1940 session in Milwaukee.

Amendment Relative to Elections

Section 2. The President, President Elect, Speaker and Vice-Speaker shall be elected by the House of Delegates. The Secretary and Treasurer shall be elected by the Council. Councilors shall be elected at a meeting of their respective district societies held within the twelve months' period prior to the annual meeting of the State Society at which the term of Councilor expires. Certification of such election, signed by the President and Secretary of the councilor district society, shall be placed in the hands of the Secretary of the State Medical Society prior to the annual meeting of the Society in the year in which the term of such Councilor expires. In the event a councilor district fails so to certify its election, the election for Councilor of such district shall be by the House of Delegates. Notices of election of a Councilor in a district shall be incorporated in a mailed notice to the members of the district at least seven days before the meeting at which the election is to be held.

Election, where more than one nomination is received, shall be by ballot and a majority of votes cast shall be necessary to elect. Each candidate for Councilor must be a resident of the district which it is proposed to represent and no person known to have solicited votes for or sought the office of Councilor shall be eligible for the current election. Other procedure essential to the election shall be governed by Robert's Rules of Order.

The officers, except the Councilors, shall be elected annually. The terms of Councilors shall be for three years, and all officers shall serve until their successors are elected and installed. There shall be elected one Councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional Councilor for each additional 250 members or major fraction thereof. As nearly as possible, one-third of the members of the Council shall be elected each year.

The President-Elect shall automatically succeed the office of President at the conclusion of his one-year term of President-Elect.

BIRTHS

A daughter, Mary Elizabeth, to Dr. and Mrs. A. D. Bussey, Two Rivers, on June 2.

A son to Dr. and Mrs. E. H. Tashkin, Milwaukee, July 7.

MARRIAGES

Mary Alice O'Leary, daughter of Dr. T. J. O'Leary, Superior, past-president of the State Medical Society, and Dr. Thomas Doyle, Superior, president of the Douglas County Medical Society, on July 24.

Dr. Edgar M. End, Wauwatosa, and Miss Audrey Plant, Milwaukee, August 3.

Dr. Charles F. Rosenberg, Waupaca, and Miss Catherine Ann Weier, Madison, August 31.

DEATHS

Dr. Robert G. Sayle, Milwaukee, died on August 1. He was 80 years of age and had spent over half a century in the practice of medicine.

He began his medical career in 1885, following graduation from Rush Medical College, Chicago. His first office was in Hales Corners, where he practiced for about twelve years. He then moved to Milwaukee where he remained in active practice until 1936, when he retired. Recently he wrote an article, "Reminiscences," which is appearing serially in current issues of *The Milwaukee Medical Times.*

During the presidential campaign of 1912, when Theodore Roosevelt was shot in Milwaukee, Dr. Sayle treated him and went to Chicago to continue the treatment for several days. For seventeen years Dr. Sayle was a member of the teaching staffs of the Wisconsin College of Physicians and Surgeons and the Marquette University School of Medicine. For over twenty-five years he served on the staff of the Milwaukee Hospital.

He was a member of the Medical Society of Milwaukee County and, in 1915, the president of that society. About three years ago he was elected to life membership in both the Milwaukee county society and the State Medical Society of Wisconsin. He was a member of the American Medical Association, the American College of Surgeons and the Milwaukee Surgical Society.

He is survived by a son and two daughters.

Dr. A. L. Bork, West Allis, died on July 20. He was forty-one years of age.

Dr. Bork was born in Milwaukee and attended school there. He was graduated in 1928 from Marquette University School of Medicine, and began the practice of his profession in West Allis immediately thereafter.

He was a member of the Medical Society of Milwaukee County and the State Medical Society of Wisconsin; he was a Fellow of the American Medical Association.

Surviving him are his widow and a daughter.

SOCIETY RECORDS

New Members

E. R. Nelson, 1300 University Avenue, Madison.

F. S. Marshall, Black Earth.

Changes in Address

E. E. Burzynski, Chicago, to 2020 West Juneau Avenue, Milwaukee.

M. J. Hermes, Racine, to General Delivery, Alhambra, California.

A. C. Krumpelbeck, Montreal, to Hurley.

C. R. Brillman, Dale, to Cobb.

G. R. Curless, Beloit, to Battle Creek Sanitarium, Battle Creek, Michigan.

E. R. Hodgson, Madison, to 700 West 168th Street, New York, New York.

O. L. Puttler, Milwaukee, to Mauston Clinic, Mauston.

RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses to practice medicine in Wisconsin after passing the examination given by the Wisconsin State Board of Medical Examiners at the Hotel Schroeder, Milwaukee, on June 25, 26 and 27, 1940.

Name	*School of Graduation*	*Year*	*Present Address*
Avey, Harry T.	Wisconsin	1939	State University Hospital, Oklahoma City, Okla.
Banner, Edward A.	Loyola	1940	Milwaukee County Hospital, Wauwatosa, Wis.
Barnstein, Norman J.	Rush	1939	16 South Henry Street, Madison, Wis.
Bloom, Norman B.	Minnesota	1940	Mt. Sinai Hospital, Milwaukee, Wis.
Boren, John W. Jr.	Northwestern	1940	363 State Street, Marinette, Wis.
Boyer, Esther L.	Wisconsin	1939	Statesan, Wis.
Brewer, Bruce J.	Marquette	1940	1637 North Fifty-first Street, Milwaukee, Wis.
Brouwer, Stephen W.	Wisconsin	1939	7514 Kenwood Avenue, Milwaukee, Wis.
Brown, Robert J.	Marquette	1940	1519 South Fifty-third Street, Milwaukee, Wis.
Calvy, William J.	Wisconsin	1939	120 East Second Street, Fond du Lac, Wis.
Cavener, Jessie L.	Oklahoma	1939	1825 West Wisconsin Avenue, Milwaukee, Wis.
Chard, Frederich H.	Wisconsin	1939	University Hospital, Ann Arbor, Mich.
Claudon, Dann B.	Wisconsin	1939	820 First Avenue, Jefferson, Wis.
Conen, Warren J.	Marquette	1940	Mt. Sinai Hospital, Milwaukee, Wis.
Cooperman, H. Harvey	Wisconsin	1939	Camp Indianola, Madison, Wis.
Cupery, Dowe P.	Marquette	1940	Markesan, Wis.
DeSalvo, Michael F.	Northwestern	1939	309 West Washington Avenue, Madison, Wis.
Dierolf, Edward J.	Marquette	1940	2253 North Sixteenth Street, Milwaukee, Wis.
Dietrich, Hervey W.	Wisconsin	1939	19 North Pinckney Street, Madison, Wis.
Donohue, John F.	Marquette	1940	2224 West Juneau Avenue, Milwaukee, Wis.
Gallogly, John A.	Marquette	1940	2905 North Cramer Street, Milwaukee, Wis.
Ginsberg, Bearl L.	Rush	1939	Mt. Sinai Hospital, Milwaukee, Wis.
Goelz, John R.	Marquette	1940	Brillion, Wis.
Goldman, Irving R.	Wisconsin	1939	3249 North Forty-ninth Street, Milwaukee, Wis.
Gramling, Anthony J.	Marquette	1940	2203 South Layton Boulevard, Milwaukee, Wis.
Greiber, Marvin F.	Wisconsin	1939	Normandale Hospital, Madison, Wis.
Hallstrand, Harold O.	Northwestern	1940	2954 North Oakland Avenue, Milwaukee, Wis.
Halser, Joseph G.	Marquette	1940	266 East Erie Street, Milwaukee, Wis.
Haukohl, Robert S.	Marquette	1940	Holy Rosary Hospital, Miles City, Mont.
Henry, Robert B.	Rush	1939	Milwaukee County General Hospital, Wauwatosa, Wis.
Hertz, Roy	Wisconsin	1939	Wisconsin General Hospital, Madison, Wis.
Hibma, Otto V.	Wisconsin	1939	2118 University Avenue, Madison, Wis.
Hiller, Glenn I.	Marquette	1940	820 East Washington Avenue, Appleton, Wis.
Hovis, William F. Jr.	Northwestern	1940	Milwaukee County General Hospital, Wauwatosa, Wis.
Jaastad, Leonard B.	Marquette	1940	3243 North Forty-ninth Street, Milwaukee, Wis.
Jahn, Richard P.	Wisconsin	1939	5566 North Thirty-ninth Street, Milwaukee, Wis.
Johnson, James R.	Harvard	1939	University Hospital, Minneapolis, Minn.
Johnson, Roger H.	Wisconsin	1939	310 North Butler Street, Madison, Wis.
Joyner, Theodore H.	College of Medical Evangelists	1940	Madison General Hospital, Madison, Wis.
Kipen, Charles S.	Wisconsin	1938	Jewish Hospital, St. Louis, Mo.
Kleinhans, Henry M.	Marquette	1940	3103 North Holton Street, Milwaukee, Wis.
Krembs, Martin A.	Rush	1939	St. Luke's Hospital, Chicago, Ill.
Kuhs, Milton L.	Wisconsin	1939	1120 South Fifty-seventh Street, West Allis, Wis.
Kurten, Louis J.	Northwestern	1939	Milwaukee County General Hospital, Wauwatosa, Wis.
Kuzma, Joseph F.	Illinois	1939	8700 West Wisconsin Avenue, Milwaukee, Wis.
Larsen, Roy B.	Wisconsin	1939	Wisconsin General Hospital, Madison, Wis.
Lindert, Merlyn C. F.	Minnesota	1939	Milwaukee County Hospital, Wauwatosa, Wis.
Marbry, George W.	Wisconsin	1939	McFarland, Wis.
Martin, Harold E.	Marquette	1940	New Holstein, Wis.
Metz, Harland I.	Marquette	1940	1841 North Third Street, Milwaukee, Wis.
Miller, Lee E.	Northwestern	1940	1228 South Fifty-fourth Street, Milwaukee, Wis.
Millman, Theodore H.	Wisconsin	1939	929 North Fourth Street, Platteville, Wis.
Moore, Donald E.	Oregon	1936	Milwaukee County Hospital, Wauwatosa, Wis.
Murphy, John T.	Marquette	1940	803 North Broadway, Green Bay, Wis.
Myers, Myron A.	Wisconsin	1939	Wisconsin General Hospital, Madison, Wis.
Nellen, James W.	Wisconsin	1939	Wisconsin General Hospital, Madison, Wis.
Neller, James L.	Harvard	1940	Luther Hospital, Eau Claire, Wis.
Newman, Carl R.	Illinois	1939	Milwaukee County Hospital, Wauwatosa, Wis.
Niles, Earl W.	Marquette	1940	3074 North Bartlett Street, Milwaukee, Wis.
Nykerk, Gerald H.	Marquette	1940	617 North Twenty-third Street, Milwaukee, Wis.
O'Donovan, Edward J.	Loyola	1939	Milwaukee County Hospital, Wauwatosa, Wis.
Ottenstein, Harold H.	Marquette	1940	Johnston Emergency Hospital, Milwaukee, Wis.
Pauly, Roman C.	Marquette	1940	Milwaukee Hospital, Milwaukee, Wis.
Petersik, John T.	Marquette	1940	Milwaukee County Hospital, Wauwatosa, Wis.

RECENT WISCONSIN LICENTIATES—Continued

Name	School of Graduation	Year	Present Address
Peterson, John R.	Marquette	1940	Milwaukee County Hospital, Wauwatosa, Wis.
Purtell, James J.	Marquette	1940	Milwaukee County Hospital, Wauwatosa, Wis.
Rabin, Allen	Rush	1939	1442 North Twelfth Street, Milwaukee, Wis.
Richardson, Roy C.	Marquette	1940	Two Rivers Bank Building, Two Rivers, Wis.
Ripsteen, Joel S.	Wisconsin	1939	4513 North Larkin Street, Milwaukee, Wis.
Rose, Robert J.	Marquette	1940	225 South Monroe Avenue, Green Bay, Wis.
Rueckert, Ray R.	Wisconsin	1939	422 West Cook Street, Portage, Wis.
Rumore, Peter C.	Loyola	1940	All Souls Hospital, Morristown, N. J.
Satory, John J.	Minnesota	1939	Milwaukee County Hospital, Wauwatosa, Wis.
Schaefer, Leroy W.	Wisconsin	1939	3309 North Frederick Avenue, Milwaukee, Wis.
Schlueter, Francis E.	Northwestern	1939	Milwaukee County Hospital, Wauwatosa, Wis.
Schmidt, Edmund J.	Marquette	1940	2906 North Forty-fifth Street, Milwaukee, Wis.
Settlage, Henry A.	Wisconsin	1939	417 Wisconsin Avenue, Waukesha, Wis.
Stahmer, Karl H.	Wisconsin	1939	313 Sixth Street, Wausau, Wis.
Steinberg, Nathan	Wisconsin	1939	University of Chicago Clinic, Chicago, Ill.
Talbot, John R.	Wisconsin	1939	St. Joseph Hospital, Marshfield, Wis.
Thatcher, Donald S.	Marquette	1940	2200 West Kilbourn Avenue, Milwaukee, Wis.
Thuerer, George R.	Wisconsin	1939	Augustana Hospital, Chicago, Ill.
Towle, Robert A.	Wisconsin	1939	University Hospitals, Iowa City, Ia.
Trier, Paul J.	Wisconsin	1939	325 Doty Street, Fond du Lac, Wis.
Turner, Ralph S.	Illinois	1939	553 Sherman Avenue, Evanston, Ill.
Vaccaro, Joseph E.	Marquette	1940	Milwaukee County General Hospital, Wauwatosa, Wis.
Vande Loo, Francis B.	Marquette	1940	633 South Superior Street, DePere, Wis.
Warvi, Wesley N.	Wisconsin	1939	Huntington Memorial Hospital, Boston, Mass,
Weisfeld, Samuel G.	Wisconsin	1939	2415 North Forty-ninth Street, Milwaukee, Wis.
White, Stoughton F.	Wisconsin	1939	Lake Mills, Wis.
Worm, George J.	Marquette	1940	2224 West Juneau Avenue, Milwaukee, Wis.
Wynn, Sidney K.	Wisconsin	1939	1631 North Forty-seventh Street, Milwaukee, Wis.
Zemlyn, Milton	Wisconsin	1938	216 South Kingshighway Boulevard, St. Louis, Mo.

The following physicians were granted licenses through reciprocity:

Name	School of Graduation	Previous Address	Present Address
Anderson, George H.	Iowa	California	111½ Strong Avenue, Stevens Point, Wis.
Bennett, Robert L.	Pittsburgh	Minnesota	2801 Monroe Street, Madison, Wis.
Birge, Edward A.	Johns Hopkins	Maryland	State Laboratory of Hygiene, Madison, Wis.
Brillman, Lester P.	Wisconsin	Illinois	2720 North Fifteenth Street, Milwaukee, Wis.
Buscalgia, Anthony T.	Loyola	Illinois	2432 West Kilbourn Avenue, Milwaukee, Wis.
Coombs, James W.	Cincinnati	Ohio	Camden, Ohio
Fellows, Ralph M.	New York & Bellevue	Missouri	Box A, Wauwatosa, Wis.
Flatley, Robert E.	Northwestern	Illinois	904 West Adams Street, Antigo, Wis.
Franke, Meta E.	Illinois	Illinois	1621 North Forty-eighth Street, Milwaukee, Wis.
Giffin, John S.	Rush	Iowa	Summit Hospital, Oconomowoc, Wis.
Goisman, Joseph A.	Wisconsin	Illinois	423 Main Street, Racine, Wis.
Hadden, Shirley L.	Illinois	Illinois	Wild Rose, Wis.
Herzog, Paul S.	Illinois	Illinois	5485 Greenwood Avenue, Chicago, Ill.
Hunt, Taylor D.	Oregon	Illinois	2525 Winnebago Street, Madison, Wis.
Keettel, William C. Jr.	Nebraska	Nebraska	State Board of Health, Madison, Wis.
Martinetti, Dominic	St. Louis	Missouri	Hurley, Wisconsin
McMahon, Raymond A.	Wisconsin	Oregon	Wisconsin General Hospital, Madison, Wis.
Motyka, Stanley J.	Arkansas	Arkansas	St. Luke's Hospital, Milwaukee, Wis.
Murphy, Michael J.	Loyola	Illinois	3035 West Wisconsin Avenue, Milwaukee, Wis.
Pierpont, John M.	Michigan	Michigan	Montreal Mining Co., Montreal, Wis.
Pudleiner, Harold G.	College of Medical Evangelists	Michigan	Hillsboro, Wis.
Schmidt, Richard H.	Johns Hopkins	Maryland	Statesan, Wis.
Seedorf, Everett E.	Wisconsin	Minnesota	St. Francis Hospital, La Crosse, Wis.
Shulman, Herbert	Iowa	Iowa	Wisconsin General Hospital, Madison, Wis.
Simpson, Frederick G.	Illinois	Illinois	Milwaukee County General Hospital, Wauwatosa, Wis.
Slocum, Harvey C.	Buffalo	New York	Wisconsin General Hospital, Madison, Wis.
Veranth, Leonard A.	Marquette	South Dakota	Ely, Minn.
Wallace, John K., II	Illinois	Illinois	Milwaukee County Hospital, Wauwatosa, Wis.
Warshell, Arnold H.	Illinois	Illinois	3728 Montrose Avenue, Chicago, Ill.
Wittler, Marie H.	Washington	Missouri	Department of Health, State Capitol, Madison, Wis.
Wyatt, Thomas E.	Vanderbilt	Tennessee	Marshfield, Wis.
Youngstrom, Clarence S.	Nebraska	Nebraska	Wisconsin General Hospital, Madison, Wis.

Over 1,500 Expected at the Ninety-Ninth Anniversary Meeting of the Society; Dean Carey of Marquette, Annual Dinner Speaker

DURING the three days of scientific sessions at the ninety-ninth anniversary meeting, scheduled for September 18, 19, and 20, upward of 1,500 members of the State Medical Society of Wisconsin are expected to register at the Milwaukee Auditorium. Substantially the entire main arena of the Auditorium will be devoted to the fifty-odd technical exhibits and the 3,000 square feet of scientific exhibits featuring industrial medicine and health. The complete program of the Society is contained in this issue of the JOURNAL on the pages that follow.

Dr. Eben J. Carey, dean of Marquette University School of Medicine since 1933 and this year chairman of the Society's Council on Scientific Work, will be the speaker of the evening on the occasion of the annual dinner (informal) to be held in the Crystal Ballroom of the Hotel Schroeder at 6:45 p.m. on September 19. Dean Carey's address, following the presentation of the Council Award, will be on the subject, "Democracy and the Doctor."

Eben J. Carey, M.D., Dean of Marquette University School of Medicine, Milwaukee

Granted the Council Award of the Society in 1938 for his scientific attainments and his outstanding services to medicine in Wisconsin in the field of graduate education, Dr. Carey is intimately known to physicians throughout the State. His achievements in portraying to the public the advances of scientific medicine while in charge of the medical section of the exhibits at the Chicago World's Fair in 1933 and 1934 have brought national acclaim and constitute a pioneer effort, which was followed in Wisconsin in 1937 by his organization and management of the Society's "Hall of Health." At this public exhibit of medicine, its accomplishments, and its efforts in Wisconsin, there were in attendance over 110,000 citizens of Milwaukee and all sections of the State.

Dr. Carey holds a commission as major in the Wisconsin National Guard and is intelligence planning and training officer of the 135th Medical Regiment. While his scientific career has been in the field of anatomy and education, his national and international acquaintanceships have given him an unusual and distinctive opportunity to observe and judge of the merits of countless present-day proposals and trends in the field of the delivery of sickness care to the American people. Dr. Carey's address will be the sole address of the evening.

Dr. Ralph P. Sproule, Milwaukee, president-elect of the State Society, will be inducted into office as president, as the concluding feature of the Thursday evening program.

WEDNESDAY MORNING, SEPTEMBER 18 . . .

A. M.

8:00 REGISTRATION . .
Main Arena, Milwaukee Auditorium

GENERAL SESSION . . .

Plankinton Hall (Second Floor)

The keynote of this program is industrial health and the subjects related to that theme

9:15 Tuberculosis Case Finding in Industry
O. A. Sander, Milwaukee

9:35 Silicosis with Special Reference to Wisconsin Industry
A. J. Lanza, Metropolitan Life Insurance Company, New York City, New York

10:00 Recess to view exhibits

Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:20 Cardiovascular Disease in Industry
W. J. Egan, assistant clinical professor of medicine, Marquette University School of Medicine, Milwaukee

10:40 Industrial Dermatoses
Harry R. Foerster, assistant professor of dermatology, University of Wisconsin Medical School, Madison, and assistant clinical professor of dermatology, Marquette University School of Medicine, Milwaukee

11:00 Industrial Health
Paul Brehm, supervisor, Industrial Hygiene Unit, State Board of Health, Madison

MARQUETTE MEDICAL ALUMNI LUNCHEON

The annual Marquette Medical Alumni Luncheon will be held in the Green Room of the Schroeder Hotel on Wednesday, September 18, at 12:15 p. m. The speaker will be Mr. Paddy Driscoll, football coach, Marquette University. Motion pictures. Entertainment. Tickets, $1.00.

NORTHWESTERN UNIVERSITY ALUMNI LUNCHEON

12:00 Noon, Wednesday, September 18, Schroeder Hotel

Guest speaker: Walter H. Nadler, M.D., president of the Medical Division of the Alumni Association (associate professor of medicine, Northwestern University Medical School, Chicago).

Committee in charge: D. E. W. Wenstrand, M.D., V. F. Lang, M.D., and R. H. Feldt, M.D., all of Milwaukee.

11:20 Program of the State Industrial Commission for Physical Examinations in Industry
Mr. H. A. Nelson, director, Workmen's Compensation, Industrial Commission of Wisconsin, Madison

11:40 Expediting Insurance Claims by Cooperation with Insurance Companies
Mr. Reuben G. Knutson, assistant claims manager in charge of compensation, Hardware Mutual Casualty Insurance Company, Stevens Point

WEDNESDAY AFTERNOON . . .

This afternoon's program is arranged to emphasize points in industrial surgery

2:00 Congenital Developmental and Acquired Characteristics of the Spine and Their Relation to Injuries—Lantern Slides
Merritt L. Jones, Wausau

2:30 First Aid in Fractures—Lantern Slides
Herman C. Schumm, associate professor of orthopedic surgery, University of Wisconsin Medical School, Madison, and clinical professor of orthopedic surgery, Marquette University School of Medicine, Milwaukee

2:50 Fractures About the Ankle — Lantern Slides
Walter P. Blount, Milwaukee

3:10 Fractures About the Wrist — Lantern Slides
Henry L. Greene, Madison

3:20 Recess to view exhibits

3:40 Treatment of Burns
A. A. Schaefer, Milwaukee

WEDNESDAY—Continued

Take time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

4:00 Some Common Every Day Injuries Around the Knee Joint
Kellogg Speed, clinical professor of surgery, Rush Medical College, University of Chicago, Chicago

7:00 OPEN HOUSE . . .
Faculty of Marquette University School of Medicine, 561 North Fifteenth Street, Milwaukee

8:00 HOUSE OF DELEGATES . . .
(Second Session), Auditorium, Marquette University School of Medicine.

At this session of the House, members of the Society will be given an opportunity to see their House of Delegates in action. A special block of seats will be reserved for the delegates, alternate delegates, and officers, with the members filling the Auditorium on both sides and in the rear. The second session of the House will thus be conducted in the midst of the membership. It is at this session, following the reports of the reference committees, that the House takes its major policy-forming actions.

9:30 SMOKER AND REFRESHMENTS . . .
Marquette University School of Medicine

PROGRAM SYNOPSIS . . .

TUESDAY, SEPTEMBER 17

P. M.
6:30—House of Delegates—Banquet Room (Fifth Floor), Schroeder Hotel

WEDNESDAY, SEPTEMBER 18

A. M.
8:00—Registration—Main Arena, Milwaukee Auditorium
9:15—General Session — Plankinton Hall (Second Floor)
10:00—Recess to view exhibits
10:20—General Session — Plankinton Hall (Second Floor)

P. M.
2:00—General Session — Plankinton Hall (Second Floor)
3:20—Recess to view exhibits
3:40—General Session — Plankinton Hall (Second Floor)
7:00—Open House, Faculty of Marquette University School of Medicine, 561 North Fifteenth Street, Milwaukee
8:00—House of Delegates (second session). Members of the Society will be special guests. Auditorium, Marquette University School of Medicine
9:30—Smoker — Marquette University School of Medicine

THURSDAY, SEPTEMBER 19

A. M.
8:00—House of Delegates—Banquet Room (Fifth Floor), Schroeder Hotel

A. M. Section meetings:
8:30—Otolaryngology—Juneau Hall North (First Floor)
9:00—Medicine—Plankinton Hall (Second Floor)
9:00—Obstetrics and Gynecology—Walker Hall (First Floor)
9:00—Radiology—Committee Room D (Second Floor)
9:00—Surgery—Engelmann Hall (Second Floor)
9:15—Pediatrics — South Kilbourn Hall (First Floor)

P. M.
12:10—Round-Table Luncheons — Schroeder Hotel
2:00—Section on Ophthalmology—Juneau Hall North (First Floor)
2:15—General Session — Plankinton Hall (Second Floor)
3:30—Recess of General Session to view exhibits
3:50—General Session — Plankinton Hall (Second Floor)
6:45—Annual Dinner — Crystal Ballroom, Schroeder Hotel

FRIDAY, SEPTEMBER 20

A. M.
9:20—General Session — Plankinton Hall (Second Floor)
10:20—Recess to view exhibits
10:40—General Session — Plankinton Hall (Second Floor)

P. M.
12:10—Round-Table Luncheons — Schroeder Hotel
2:15—General Session — Plankinton Hall (Second Floor)

HOUSE OF DELEGATES . . .

Tuesday, 6:30 p. m.—Banquet Room (Fifth Floor), Schroeder Hotel
Wednesday, 8 p. m.—Auditorium, Marquette University School of Medicine
Thursday, 8 a. m.—Banquet Room (Fifth Floor), Schroeder Hotel

THURSDAY MORNING, SEPTEMBER 19 . . .

A. M.

8:00 HOUSE OF DELEGATES . . .
Banquet Room (Fifth Floor) Schroeder Hotel

SECTION ON MEDICINE . . .

Plankinton Hall (Second Floor)

O. O. Meyer, associate professor of medicine, University of Wisconsin Medical School, Madison, chairman

A. M.

9:00 The Treatment of Advanced Portal Cirrhosis
John A. Schindler, Monroe
Discussant:
9:20 Karl H. Doege, Marshfield

9:30 Some Aspects of the Treatment of Acute and Chronic Arthritis
Chester Keefer, director, Robert Dawson Evans Memorial Hospital, Boston, Massachusetts; associate professor of medicine, Harvard Medical School, and Wade professor of medicine, Boston University School of Medicine

10:00 Polycythemia
A. A. Holbrook, Milwaukee
Discussant:
10:20 Chester Keefer, Boston

10:30 Recess to view exhibits

11:00 Calcareous Aortic Stenosis
W. A. Killins, Green Bay
Discussants:
11:20 Charles Burke, Madison
11:25 F. J. Hirschboeck, Duluth, Minnesota

11:30 The Diagnosis of Brucellosis
C. V. Seastone, Jr., assistant professor of bacteriology, University of Wisconsin Medical School, Madison

SECTION ON OTOLARYNGOLOGY . . .

Juneau Hall North (First Floor)

T. F. McCormick, assistant clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee, chairman

A. M.

8:30 Acute Laryngotracheal Bronchitis
W. J. Troup, Green Bay
Discussant:
8:55 N. S. Simons, Whitehall

9:05 Surgical Treatment of Otosclerosis
George E. Shambaugh, Jr., associate clinical professor of otology and laryngology, and chairman of the Department of Otology and Laryngology, Rush Medical College, University of Chicago, Chicago, Illinois
Discussant:
9:40 Wellwood M. Nesbit, professor of otolaryngology, University of Wisconsin Medical School, Madison

9:50 Recess to view exhibits

10:20 Early and Late Treatment of Traumatic Injuries of the Face
Gordon B. New, professor of otolaryngology and rhinology, University of Minnesota Graduate School, Minneapolis–Rochester; The Mayo Clinic, Rochester, Minnesota
Discussant:
10:55 Matthew Federspiel, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

11:05 Vertigo
W. E. Grove, clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee
Discussant:
11:35 J. K. Trumbo, Wausau

SECTION ON OBSTETRICS AND GYNECOLOGY . . .

Walker Hall (First Floor)

Roland S. Cron, clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee, chairman

A. M.

9:00 Occult Hypothyroidism in Wisconsin Women
Addie M. Schwittay, Madison

9:20 Maternal Care and Maternal Mortality
Edwin F. Daily, Children's Bureau, United States Department of Labor, Washington, D. C.; instructor in department of obstetrics and gynecology, University of Chicago (on leave of absence)
Discussant:
9:40 John W. Harris, professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

9:50 Recess to view exhibits

A. M.

10:10 Management of the Third Stage of Labor
Charles J. Newcomb, Milwaukee

Discussant:

10:30 Henry J. Olson, assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

10:40 Irregular Shedding and Regeneration of the Endometrium as a Clinical and Diagnostic Problem
John L. McKelvey, professor of obstetrics and gynecology, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis, Minnesota

Discussant:

11:00 G. H. Hansmann, Milwaukee

11:10 Lantern Demonstrations of Cervical Lesions of the Uterus
Charles E. Galloway, assistant professor of obstetrics and gynecology, Northwestern University Medical School, Chicago; Evanston, Illinois

Discussant:

11:30 Harold W. Shutter, Milwaukee

SECTION ON RADIOLOGY . . .

Committee Room D (Second Floor)

T. J. Pfeffer, Racine, chairman

9:00 A Case Report
H. W. Hefke, Milwaukee

9:15 A Case Report
W. T. Clark, Janesville

9:30 Photofluoroscopy and Roentgenography as Used at the Wisconsin State Sanatorium
H. M. Coon, Statesan

9:50 A Case of Bone Metastases
L. V. Littig, Madison

10:05 A Case Report
F. H. Kuegle, Janesville

10:20 Recess to view exhibits

> The technical exhibits make it possible to present the annual meeting without a registration fee. Express your appreciation to the exhibitors by visiting their booths.

10:40 A Gastro-Intestinal Case Report
I. G. Ellis, Madison

10:55 Cholangiography
I. I. Cowan, Milwaukee

11:10 A Surgical Case Report
R. P. Potter, Marshfield

11:25 A Therapeutic Case Report
E. A. Pohle, professor of radiology, University of Wisconsin Medical School, Madison

11:40 Diaphragmatic Hernia
S. A. Morton, Milwaukee

SECTION ON SURGERY . . .

Engelmann Hall (Second Floor)

F. Gregory Connell, Oshkosh, chairman

As the surgical case is often, at some time, a medical problem, and as we have passed, chronologically speaking, through the "Technical Thirties" and have entered the "Physiological Forties," this program will consider certain fundamental principles of diagnosis and treatment instead of designated disease, trauma, or technical details.

The first half of this sectional program is devoted to diagnosis and the second half to treatment.

Diagnosis

Extra-abdominal diseases that may cause abdominal symptoms

A. M.

9:00 Abdominal Symptoms—Repercussions of Personality Disorders
E. G. Billings, associate professor of psychiatry, University of Colorado School of Medicine, Denver, Colorado

9:20 Cardiovascular-renal and Pulmonary Diseases
Arthur R. Elliott, clinical professor of medicine, Rush Medical College, University of Chicago, Chicago, Illinois

9:40 Miscellaneous Diseases (Allergy; Endocrine, Hormonal, and Hematologic; Vitamins, etc.)
F. W. Madison, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee

Discussants:

10:00 Carl Eberbach, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

10:10 J. W. Gale, associate professor of surgery, University of Wisconsin Medical School, Madison

10:20 Recess to view exhibits

Treatment

Preoperative and Postoperative Management

10:30 In Shock and Hemorrhage
Carl Williamson, Green Bay

Discussant:

10:50 Sigurd Gundersen, La Crosse

11:10 In Peritonitis and Ileus
Grover Penberthy, professor of clinical surgery, Wayne University College of Medicine, Detroit, Michigan

Discussants:

11:30 E. H. Mensing, Milwaukee

11:40 M. E. Gabor, Milwaukee

SECTION ON PEDIATRICS . . .

South Kilbourn Hall (First Floor)

H. Kent Tenney, associate professor of pediatrics, University of Wisconsin Medical School, Madison, chairman

A. M.

9:15 Encephalography in Children; Indications and Interpretations
M. G. Peterman, Milwaukee
Discussant:
9:35 L. M. Simonson, Sheboygan

9:40 The Problem of Squint in Young Children
E. E. Neff, associate professor of ophthalmology, University of Wisconsin Medical School, Madison
Discussant:
10:00 H. Kent Tenney, Madison

10:05 Recess to view exhibits

10:25 Allergy in Children with Special Reference to Infantile Eczema
Gerald M. Cline, Bloomington, Illinois
Discussant:
10:45 F. R. Janney, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee; Wauwatosa

10:55 Treatment of Pneumonia in Children, with Sulfapyridine
John A. Bigler, assistant professor of pediatrics, Northwestern University Medical School, Chicago; Highland Park, Illinois
Discussant:
11:25 J. M. Freeman, Wausau

11:35 Management of the Premature Infant
H. O. McMahon, clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee
Discussant:
11:55 H. E. Van Riper, Madison

THURSDAY NOON ROUND TABLES . . .

12:10 P. M. Schroeder Hotel

1. Bedside Medicine and New Drugs
O. O. Meyer, associate professor of medicine, University of Wisconsin Medical School, Madison
Parlor A, Fourth Floor

2. Bedside Medicine and New Drugs
F. W. Madison, Milwaukee
Parlor B, Fourth Floor

3. Treatment of Acute Episodes in Medical Practice
Francis Murphy, clinical professor of medicine, Marquette University School of Medicine, Milwaukee
Parlor C, Fourth Floor

4. Do-Nots in Office Proctology
W. A. Fansler, clinical associate professor of surgery, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis, Minnesota
Parlor D, Fourth Floor

5. The Use of Vitamins in Ophthalmology
Peter C. Kronfeld, dean of instruction, The Illinois Eye and Ear Infirmary, Chicago, Illinois
Parlor E, Fourth Floor

6. Ocular Allergy
F. Bruce Fralick, professor of ophthalmology, University of Michigan Medical School, Ann Arbor, Michigan
Parlor F, Fourth Floor

7. Prevention and Treatment of Tetanus
John A. Bigler, Highland Park, Illinois
Parlor G, Fourth Floor

8. The Prevention and Treatment of Vomiting of Pregnancy
Madeline Thornton, assistant professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison
Parlor H, Fourth Floor

9. The Treatment of Pain and Drug Addiction
M. H. Seevers, associate professor of pharmacology, University of Wisconsin Medical School, Madison
Parlor I, Fourth Floor

10. Nutritional Diseases With Special Reference to the Vitamin Deficiencies
Harold Marsh, Madison
Committee Room, Fifth Floor

11. Intestinal Obstruction; Its Clinical Management
E. R. Schmidt, professor of surgery, University of Wisconsin Medical School, Madison, and Grover Penberthy, Detroit, Michigan
Pere Marquette Room, Fifth Floor

12. Personality Reactions Following Lower Abdominal Surgery in Women
E. G. Billings, Denver, Colorado
English Room, Fifth Floor

13. X-ray Treatment of Brain Tumors
E. L. Jenkinson, associate professor of radiology, Northwestern University Medical School, Chicago, Illinois
Pine Room, Fifth Floor

14. Treatment of Chronic Suppurative Otitis Media
George E. Shambaugh, Jr., Chicago, Illinois
Room B, Fifth Floor

15. Deep Infections of the Neck
Gordon B. New, Rochester, Minnesota
Room C, Fifth Floor

16. Some Newer Concepts of Premature Separation of the Normally Implanted Placenta
John McKelvey, Minneapolis, Minnesota
Room D, Fifth Floor

17. Treatment of Arthritis
Chester Keefer, Boston, Massachusetts
Room E, Fifth Floor

18. Discussion of Personal Problems Should M-Day Become an Actuality
Major L. W. Peterson, commanding officer, Third Battalion, 135th Medical Regiment, Sun Prairie
Room F, Fifth Floor

19. Management of Urinary Tract Infections
C. C. Higgins, Cleveland, Ohio
Lounge Section of Banquet Room, Fifth Floor

20. Analgesia and Anesthesia in Labor
Charles E. Galloway, Evanston, Illinois
Room 619, Sixth Floor

THURSDAY AFTERNOON . . .

SECTION ON OPHTHALMOLOGY . . .

Juneau Hall North (First Floor)

Mark E. Nesbit, Madison, chairman

P. M.

2:00 The Pharmacology of Paredrine and Prostigmine
R. O. Ebert, Oshkosh
Discussant:
2:25 A. H. Pember, Janesville

2:35 Uveitis with Secondary Glaucoma
F. Bruce Fralick, Ann Arbor, Michigan
Discussant:
3:05 Clarence K. Schubert, Madison

3:15 Recess to view exhibits

3:35 The Practical Value of Gonioscopy for the Understanding, Diagnosis, and Treatment of Glaucoma
Peter C. Kronfeld, Chicago, Illinois
Discussant:
4:10 G. L. McCormick, Marshfield

GENERAL SESSION . . .

Plankinton Hall (Second Floor)

P. M.

2:15 Our Mental Health
(Rogers Memorial Lecture)
Franklin G. Ebaugh, professor of psychiatry, University of Colorado School of Medicine, Denver, Colorado

2:50 Surgical Treatment of Hemorrhoids
W. A. Fansler, Minneapolis, Minnesota

3:10 Lesions of the Diaphragm (Diaphragmatic Hernia, Congenitally Short Esophagus, Thoracic Stomach, and Absence of the Diaphragm)
E. L. Jenkinson, Chicago, Illinois

BADGES REQUIRED

Only members wearing badges will be admitted to the scientific sessions of the annual meeting. Get your badge and program at the registration desk in the Milwaukee Auditorium. If you lose your badge, another may be secured.

YOUR NUMBER IN MILWAUKEE!

Special telephones will be installed in the Auditorium to receive calls for physicians. Tell your office you can be reached at

BROADWAY 8030

3:30 Recess to view exhibits

3:50 The Present Status of Chemotherapy in the Treatment of Infectious Diseases
Chester Keefer, Boston, Massachusetts

4:10 Secretary's Report
Mr. J. G. Crownhart, secretary, State Medical Society of Wisconsin

4:20 Common Pitfalls in Diagnosis
Frank Hirschboeck, Duluth, Minnesota

4:40 Arteriosclerotic Toxemia of Pregnancy
John L. McKelvey, Minneapolis, Minnesota

P. M.

6:45 ANNUAL DINNER . . .
(Informal)
Crystal Ballroom,
Schroeder Hotel
Speaker: Eben J. Carey, dean, Marquette University School of Medicine, Milwaukee
Subject: "Democracy and the Doctor."

FRIDAY MORNING, SEPTEMBER 20 . . .

GENERAL SESSION . . .

Plankinton Hall (Second Floor)

A. M.

9:20 Clinical Aspects of Bronchogenic Carcinoma
George C. Owen, Oshkosh

9:40 Prostatic Resection; Some Facts and Fancies Revealed by Time
James C. Sargent, clinical professor of urology, Marquette University School of Medicine, Milwaukee

10:00 President's Address
R. P. Sproule, Milwaukee

10:20 Recess to view exhibits

10:40 The Internist and Acute Disease of the Abdomen
Samuel H. Boyer, Jr., Duluth, Minnesota

11:00 Management of Patients with Renal Lithiasis
C. C. Higgins, Cleveland, Ohio

11:30 Hydronephrosis
Fred E. B. Foley, clinical associate professor of urology, University of Minnesota Medical School, and clinical associate professor of surgery, University of Minnesota Graduate School, Minneapolis; St. Paul, Minnesota

FRIDAY NOON ROUND TABLES . . .

12:10 P. M. Schroeder Hotel

1. Preventable Factors in Maternal Mortality
Edwin F. Daily, Washington, D. C.
Parlor A, Fourth Floor

2. Choice of Operation for Viscal Neck Obstruction
Fred E. B. Foley, St. Paul, Minnesota
Parlor B, Fourth Floor

3. Preferable Techniques in Taking X-ray Films of the Chest, Their Interpretation and Interesting Cases
A. A. Pleyte, assisted by S. A. Morton, Milwaukee, and G. C. Owen, Oshkosh
Parlor C, Fourth Floor

4. The Newer Drugs; Clinical Use of Sulfanilamide and Its Allies
Francis Murphy, Milwaukee
Parlor D, Fourth Floor

5. Diagnosis and Treatment of Hemorrhagic Diseases
A. J. Quick, associate professor of pharmacology, Marquette University School of Medicine, Milwaukee
Parlor E, Fourth Floor

6. Industrial Medicine With Special Reference to the Effects of Toxic Dusts and Solvents
Elston Belknap, assistant clinical professor of medicine, Marquette University School of Medicine, Milwaukee
Parlor F, Fourth Floor

7. Allergy and Dermatology
T. L. Squier, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee, and Harry R. Foerster, Milwaukee
Parlor G, Fourth Floor

8. The Uses and Abuses of Pituitary Extract in Obstetrics
John W. Harris, Madison
Parlor H, Fourth Floor

9. Orthopedics and the General Practitioner
R. M. Carter, Green Bay
Parlor I, Fourth Floor

10. Surgery of the Biliary System
S. E. Gavin, Fond du Lac
Committee Room, Fifth Floor

11. Care of the Cardiac Cripple During Childhood and Adolescence
Maurice Hardgrove, Milwaukee
Pere Marquette Room, Fifth Floor

12. Bedside Medicine and New Drugs
O. O. Meyer, Madison
English Room, Fifth Floor

13. Arthritis; the Wisconsin Rheumatism Association Has Something to Tell
M. C. Borman, Millard Tufts, and W. J. Egan, Milwaukee
Pine Room, Fifth Floor

14. Discussion of Personal Problems Should M-Day Become an Actuality
Major Eben J. Carey, intelligence planning and training officer, 135th Medical Regiment (dean, Marquette University School of Medicine, Milwaukee)
Room B, Fifth Floor

15. Discussion of Personal Problems Should M-Day Become an Actuality
Lieutenant Colonel W. J. Bleckwenn, executive officer, 135th Medical Regiment (professor of neuropsychiatry, University of Wisconsin Medical School, Madison)
Room C, Fifth Floor

FRIDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall (Second Floor)

2:15 Industrial Health as it Relates to National Preparedness

Stanley J. Seeger, Milwaukee

2:35 Physiologic Problems Involved in Aviation; Anoxemia and Its Prevention

Walter M. Boothby, professor of experimental metabolism, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota; head of Section on Metabolic Research and of the Laboratory for Aviation Medicine, The Mayo Clinic, Rochester, Minnesota, and

W. Randolph Lovelace, II, assistant surgeon, The Mayo Clinic, Rochester, Minnesota

2:55 West Indies in the Headlines

Colonel Fred T. Cruse, Field Artillery, United States Army, Madison

3:05 What Confronts America and the Western Hemisphere Today

Brigadier General Ralph M. Immell, the Adjutant General of Wisconsin, Madison

3:20 The Physician and Conscription

Colonel W. F. Lorenz, chief surgeon, Wisconsin National Guard (professor of neuropsychiatry, University of Wisconsin Medical School), Madison

Scientific Exhibits . . .

BOOTHS 1, 2, 3 AND 4

Cooperative Medical and Engineering Effort in Industrial Health

E. G. Meiter, Ph.D., Industrial Hygiene Department, Employers Mutuals; E. L. Belknap, Milwaukee; O. A. Sander, Milwaukee; Norbert Enzer, Milwaukee; Mr. W. A. Vollmer, Milwaukee

This exhibit will be a cooperative effort featuring both medical and engineering methods for the control of health and safety of industrial workers. Medical aspects will feature the Wisconsin Physical Examination Program as sponsored by the Industrial Commission. In addition, x-ray films illustrating both silicotic and non-silicotic lungs will be shown. There will also be on display, lung specimens showing silicosis, anthracosis, siderosis, and asbestosis. Lead as a toxic dust will be treated from both the standpoint of treatment and prevention of poisoning.

Engineering control of occupational diseases will be illustrated by instruments and devices used for measuring and eliminating the toxic agents in air. The accident prevention phases of the problem will be devoted primarily to an exhibition of model dies designed for the elimination of punch press accidents. An exhibit of various types of safety clothing will be included.

BOOTH 5

Health for Industry by Industry

Committee on Healthful Working Conditions, National Association of Manufacturers

The exhibit of the Committee on Healthful Working Conditions of the National Association of Manufacturers portrays the broad approach to the problem of industrial health work, as well as interesting details essential to a consideration of employe health work. In addition, typical results of good company health programs are presented to demonstrate what may be expected from an efficient program to improve employe health.

BOOTH 6

Sick Absenteeism Recording

P. A. Neal, National Institute of Health, United States Public Health Service

This exhibit has been prepared by the Division of Industrial Hygiene (Acting Chief, Dr. P. A. Neal) for the purpose of acquainting the medical profession, first, with the importance to labor, management and preventive medicine of the recording of absenteeism among industrial workers, and, second, with a practical plan believed to yield useful records.

The exhibit presents the three forms necessary for the recording of absences according to the plan proposed, and, with the use of charts based on industrial morbidity experiences, the justification for recording data on absenteeism.

BOOTHS 7 AND 8

Artificial Air for Use by Pressure Workers

Edgar End, Department of Physiology, Marquette University School of Medicine

Medical research has made possible every major advance during the past half century in the field of pressure work. This exhibit deals particularly with

the development of artificial helium-oxygen breathing mixtures for use under increased atmospheric pressure. These mixtures have already made possible a new world record for deep diving and have been adopted by the United States Navy. Their development is the result of applying medical knowledge to an important industrial problem. The exhibit includes the diving suit in which the present world record was established and other recently developed equipment for use under increased atmospheric pressure.

BOOTH 9

Milkers' Nodules

F. T. Becker, Duluth, Minnesota

This exhibit shows illustrations of four typical cases of milkers' nodules. Pathology of various stages of the infection, diagnostic criteria and differential diagnosis are demonstrated.

BOOTH 10

Wisconsin Rheumatism Association

M. C. Borman, Milwaukee

This exhibit stresses the importance of early differential diagnosis in the management of rheumatism. X-ray studies of the hand, based upon the work of Scott, are presented. Examples of rheumatoid arthritis, osteoarthritis, infective and gouty arthritis are shown, with x-ray films and case histories.

Interpretation of x-ray pictures is presented according to the following form.

1. Decalcification (systemic—regional—local)
2. Bone production (lipping—osteophytes)
3. Bone destruction (active—atrophic)
4. Joint space
5. Ankylosis (bony—fibrous)
6. Changes in soft tissue (atrophy—swelling—effusion)

   Diagnosis: Type of Arthritis

The tremendous importance of the problem of rheumatism is graphically pictured from reports of the American Committee for the Study of Rheumatism.

An outline of the purpose and objectives of the Wisconsin Rheumatism Association is displayed. Pamphlets stating the aims of the Wisconsin Rheumatism Association will be distributed to those interested.

A question box will be available where questions concerning the management of the rheumatic patient can be deposited.

BOOTHS 11 AND 12

Diseases of the Thyroid Gland

Arnold S. Jackson, Madison

This exhibit will feature: Models and charts on diagnosis and treatment of cretins; maps and charts showing growth of cretinism and distribution of the 500 cases reported in the United States; colored illustrations showing technic of thyroidectomy by electrosurgery for exophthalmic goiter; colored illustrations and models of the various types of goiter, their distinguishing characteristics and the methods of treatment; illustrations, charts and data on hypothyroidism and myxedema illustrating typical and atypical cases, signs, symptoms, methods of treatment and results; moving pictures of cretins and the technic of thyroidectomy.

BOOTHS 13, 14 AND 15

The Pneumoconioses

American Medical Association

The exhibit consists of panels and translight cases which describe the essential facts about benign pneumoconiosis. Simple nodular silicosis, simple conglomerate silicosis, tuberculo-silicosis, and asbestosis.

Publications have been prepared on the etiology and the pathology of pneumoconiosis which will be available on request.

BOOTH 16

Industrial Health in Medical Practice

Council on Industrial Health, American Medical Association

The exhibit consists of charts describing the essential medical factors in industrial health, the present facilities designed to cope with the problems, and other details describing the opportunities open to physicians with proper qualifications in the field of industrial medicine, surgery, and hygiene.

BOOTHS 17, 18 AND 19

Industrial Health Service in Wisconsin

Wisconsin State Board of Health and Wisconsin Industrial Commission

The exhibit material will be composed of field equipment of various kinds for the determination of atmospheric concentrations in industrial environments of various dusts, fumes, vapors and gases.

The exhibit material will be presented as follows:

1. Material from the Industrial Hygiene unit. State Board of Health.
   a. Field equipment for evaluating various industrial health hazards. With this equipment it is possible to collect atmospheric samples of dusts, fumes, vapors and gases in all types of industrial establishments. The equipment will be in operation, showing the sampling procedure.
   b. Equipment and apparatus for making ventilation studies, and such environmental conditions as humidity and temperature.

2. Industrial Commission Exhibit Material
   a. Statistical charts and graphs showing Wisconsin occupational disease experience under the workmen's compensation act over a period of years.
   b. Respiratory protective equipment.
   The equipment exhibit will include a variety of types suitable for protection against various harmful materials encountered in industry.

BOOTH 20

Lead Absorption and Intoxication in Everyday Life

G. H. Hansmann, and M. C. Perry, M.A.
Columbia Hospital

The exhibit will be a series of transparencies picturing charts, roentgenograms, and photomicrographs representing lead absorption and its consequences in everyday life.

BOOTHS 21 AND 22

Tuberculosis in Industry

Wisconsin Anti-Tuberculosis Association

With the continued reduction in the death rate from tuberculosis, the program for its control must be modified to meet changing conditions. Statistical studies show that tuberculosis is primarily a disease of lower income levels and that men in industry constitute one of the greatest remaining pockets of mortality and morbidity.

Through the use of enlarged spot maps, the exhibit will show the location of deaths from tuberculosis in the Milwaukee area for the key years 1930, 1935 and 1939, centering each year in the more heavily industrialized sections of the city. Charts and posters will also show the relationship of deaths from tuberculosis to various occupational and rental levels.

BOOTH 23

Malaria in the Experimental Laboratory

Harry Beckman and Robert K. Ota, Marquette University School of Medicine

The exhibit will include microscopic slides and live specimens of larvae, pupae, mosquitoes, and canaries to be shown in three divisions as follows:

The asexual stage in the bird:

1. Normal (uninfected) canary blood.
2. Infected canary blood.
   a. before atabrin
   b. after atabrin

The mode of transmission:

1. The rearing of mosquito larvae, pupae and adult mosquitoes.
2. Method of infecting birds or mosquitoes.
3. Apparatus for:
   a. drug administration.
   b. making blood smears.
   c. sporozoite injection.

The sexual cycle in the mosquito:

1. gametocytes.
2. exflagellation.
3. oocysts.
4. sporozoites.

BOOTH 24

A Health Program for Industry Based on a Modern School Hygiene Plan as Seen Through the Eyes Eyes of a Village Health Commissioner

Edwin G. Gute, Commissioner of Health, Villages of Whitefish Bay and Fox Point

The exhibit presents an interesting comparison of two procedures dealing with preventive medicine. An attempt is made to suggest a health program for industry using as a basis experience in administering a modern school hygiene program as practiced in the village of Whitefish Bay.

Many of the public health activities which are at present being conducted in the schools of a highly restricted residential community like Whitefish Bay in order to promote the health of the child can easily be effectively duplicated in industry to improve the health of the worker and the worker's family.

The exhibitor believes we are approaching the time when a greater number of small industrial plants will be served by a larger group of general practitioners sincerely interested and better trained in industrial medicine and hygiene. The medical profession has led the way in this respect as is attested by the fact that for many years general practitioners have been serving as part-time health commissioners and school doctors in small communities throughout the state.

A cursory inspection of this exhibit impresses one almost immediately with the fact that public health and industrial medicine are closely allied.

It is the hope of the exhibitor that many industries both small and large will see the need and realize the advantages to be gained both for the worker as well as the employer by the institution of a health program.

BOOTH 25

Milwaukee Convalescent Serum Center

Columbia Hospital, Milwaukee, Maurice Hardgrove

This exhibit will consist of easily read large graphs showing the results obtained after the use the convalescent sera in the prevention and treat-

ment of certain contagious diseases—scarlet fever, measles, mumps, etc. In addition to this, there will be a demonstration of the preparation of plasma and serum transfusions, as well as some reference to the banking of blood. At the present time, there is tremendous interest in the use of plasma and serum in the treatment of war wounds such as shock and burns, and the attempt will be made to make this exhibit one of current interest.

BOOTH 26

The Diabetic Child

Milwaukee Children's Hospital, George F. Kelly, Nell Clausen, Dietician

The Children's Hospital Exhibit on Diabetes in Children will attempt to show the incidence of this disease, the symptoms, methods of making a diagnosis, and treatment.

Detailed information on diet, such as protein requirement and total calories, will be part of the display together with amounts of carbohydrate, fats, and vitamins necessary in different age groups in children.

The use of insulin will be dealt with in the treatment of coma and control of diabetes.

The routine of the diabetic child in our clinic, the education of the family in diabetic care, and the value of information on disease will receive emphasis in the display.

The exhibitors have been taking four blood sugars during the day once a month on all patients for about two years. Charts showing their blood sugar curves should prove interesting and really tell the variation that may occur in carbohydrate metabolism in diabetic children.

BOOTHS 27 AND 28

Highway Accidents and Alcohol

Committee on Safety on Public Highways

Various forms of testing apparatus will be demonstrated which will give information about reaction time, binocular vision, effect of glare, etc. In addition there will be an actual demonstration of methods of confirming alcoholic intoxication by means of chemical analyses. Harger's method of examining the breath will be featured since specimens can be obtained from visitors and tested within a few minutes. It will be possible to determine the amount of alcohol in the blood at the time of the examination and also to estimate the amount of alcohol recently consumed by the individual.

BOOTH 29

Vital Statistics

Wisconsin State Board of Health

Recent changes in the makeup of birth and death certificates adopted by the Census Bureau at Washington to meet current statistical demands will be made clear in an exhibit offered by the Board's Bureau of Vital Statistics. Certain statistical trends in some of the leading causes of death, past and present, will be presented in graphic form to emphasize marked reductions in deaths due to preventable diseases, and marked increases in certain other diseases associated with older age groups that are commonly referred to as postponable diseases.

BOOTH 30

Maternal and Child Health

Wisconsin State Board of Health

Methods being employed by the State Board of Health to get patients under the care of a physician early in pregnancy, services available to physicians to promote adequate prenatal care, maternal and infant statistics, and other matters involved in the reduction of maternal and infant deaths in Wisconsin will be portrayed in the booth presenting certain phases of the maternal and child health program of the Board. Included in this exhibit will be one of the incubators for the care of prematures recently made available to physicians and hospitals through the Bureau of Maternal and Child Health, as well as a presentation of hospital facilities for obstetrical care available in the state.

BOOTH A

The Premature Infant Feeding and Nursing Bureau, Inc.

Medical Society of Milwaukee County, James O. Kelley, Executive Secretary

Two years ago the Medical Society of Milwaukee County saw a distinct need for a premature infant feeding and nursing bureau. After surveying the available facilities it was decided that the Visiting Nurse Association of Milwaukee was the best equipped agency to carry on the activities of the Premature Infant Feeding and Nursing Bureau. Due to the many problems which would be confronted by such a project, it was deemed advisable, on the advice of legal counsel, to incorporate this Bureau as a separate corporation.

The purpose of the Premature Infant Feeding and Nursing Bureau is to promote the care and treatment of prematurely born and immature infants; to help in the reduction of infant mortality; to operate and maintain mothers' milk stations for the purpose of supplying breast milk to premature and immature infants; to further the scientific and professional knowledge in regard to the care and treatment of premature and immature infants, and such other business as is incidental and collateral to the said purposes.

During the year of 1939, 16,620¼ ounces or 519½ quarts of milk were secured from eighteen donors

who reported to the milk station 996 times in 321 days. This is an average of about fifty visits per donor per year. These donors were paid $1,000.97. This milk was then disposed of in three ways; 6,413½ ounces were sold at the full fee of 10 cents per ounce, 4,814 ounces were sold on a part-fee basis, that is, those people paid what they felt they could afford to pay, and 5,580½ ounces were distributed on a gratis basis, giving a total of 16,808 ounces or 525½ quarts to 132 patients who called at the milk station 833 times for the milk.

This produced an income of $682.15 showing a deficit of $318.82.

During the time that the Bureau has been in operation all the hospitals in the community set up minimum requirements for hospital care of premature infants and minimum requirements for nursing care of prematures.

We believe it is also noteworthy to mention that the Health Commissioner of the City of Milwaukee, in his annual report for the year of 1939, pointed out that the premature mortality rate had been decreased to a considerable extent since The Premature Infant Feeding and Nursing Bureau had been in operation.

BOOTH B

Medical Library Service

University of Wisconsin Medical School, Gladys Ramsey, Librarian

The Medical Library Service exhibit will explain the extension loan system by which physicians of Wisconsin borrow the latest medical literature at the small cost of postage and packing.

Representative current journals will be shown; the new editions of medical textbooks, some standard reference works, and a few medical histories and biographies will be available for examination. Charts will show the growth and distribution of loans.

New lists of books and journals available and letters explaining the service will be distributed.

BOOTH C

Testicular Deficiency

Walter M. Kearns, Milwaukee

This exhibit includes demonstrations of the various methods of replacement and substitution therapy in various types of testicular deficiency, including infertility, castration, eunuchoidism, maldescent of the testicle, as well as methods of urinary androgenic assay. The entire exhibit is transilluminated. The films are made up of colored photographs, colored charts, diagrams and discussions.

BOOTH D

Oxygen in Aviation and Medicine

W. M. Boothby, W. R. Lovelace, A. H. Bulbulian, C. W. Mayo, The Mayo Foundation

A demonstration of the problem of aeroembolism and how to avoid it. In this exhibit booth will be an individual low pressure chamber which has been used in connection with demonstrations at meetings of the Institute of the Aeronautical Sciences. This will demonstrate how, by using the decompression chamber and with the individual in the chamber breathing 100 per cent oxygen for one-half hour while exercising, he would then be able to ascend to 35,000 or 40,000 feet in a matter of ten minutes. This will be a very interesting demonstration, as it illustrates the methods of training young aviators to take care of themselves at high altitudes.

GOLF TOURNAMENT

The Annual Golf Tournament of the State Medical Society will be held at the Ozaukee Country Club, Tuesday, September 17 at 1 p.m. The registration fee of $4 covers the green fee (including cost of a morning practice round for those who wish to "warm up" or get acquainted with the course), refreshments and dinner at 6 p.m. Reservations should be made *at least three days before the tournament* with the Medical Society of Milwaukee County, 208 East Wisconsin Avenue, Milwaukee. Send in your name, address, the name of your home club, your board average and handicap along with the $4 registration fee.

Jim Kelley, executive secretary of the Medical Society of Milwaukee County, writes: "The best directions for reaching the Ozaukee Country Club would be to take Highway 57 leading north from Milwaukee to the Village of Mequon, a distance of about ten miles, and turn to the right at the cross roads in the center of the village. Go about one-half mile east and turn to the right again and continue to the Ozaukee Country Club."

Remember!

. . The date: Tuesday, September 17

. . The time: 1 p.m.

The prizes: President's Cup, Secretary's Cup, Blind Bogey and many others.

And make your reservations EARLY with:
The Medical Society of Milwaukee County,
208 East Wisconsin Avenue,
Milwaukee, Wisconsin.

MEMBERS—1940 HOUSE OF DELEGATES

Society	*Delegate*	*Alternate Delegate*
Ashland–Bayfield–Iron	J. W. Prentice, Ashland	C. J. Smiles, Ashland
Barron–Washburn–Sawyer–Burnett	A. S. White, Rice Lake	R. W. Adams, Chetek
Brown–Kewaunee–Door	P. R. Minahan, Green Bay	W. W. Kelly, Green Bay
	O. A. Stiennon, Green Bay	W. E. Leaper, Green Bay
Calumet	F. P. Knauf, Kiel	J. W. Goggins, Chilton
Chippewa	C. N. B. Hatleberg, Chippewa Falls	A. J. Somers, Chippewa Falls
Clark	M. C. Rosekrans, Neillsville	B. H. Dike, Owen
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	A. R. Tormey, Madison	S. A. McCormick, Madison
Dodge	A. G. Hough, Beaver Dam	F. T. Clark, Waupun
Douglas	T. J. O'Leary, Superior	Charles W. Giesen, Superior
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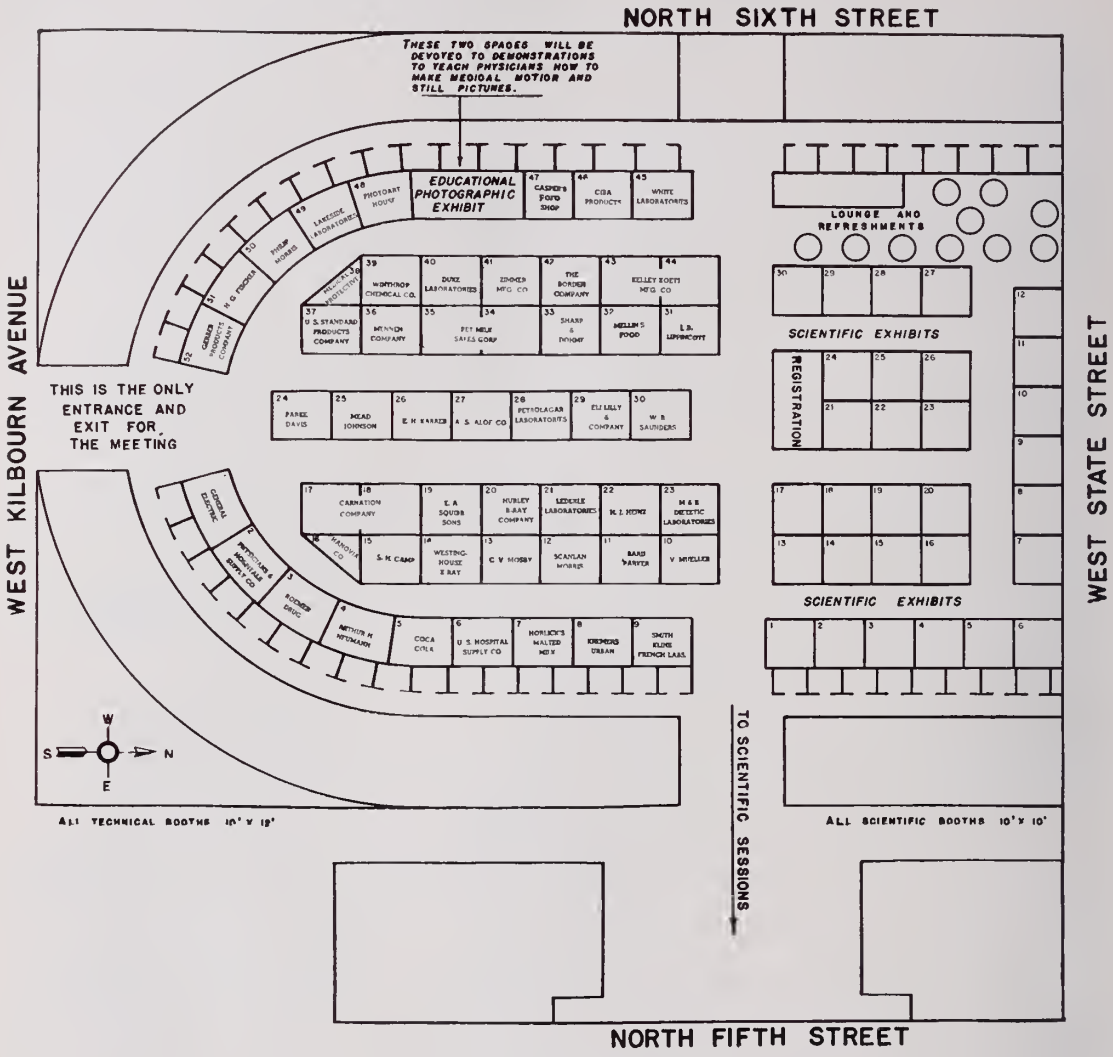
Fond du Lac	D. J. Twohig, Fond du Lac	J. C. Devine, Fond du Lac
Forest	G. W. Ison, Crandon	E. G. Ovitz, Laona
Grant	E. H. Spiegelberg, Boscobel	J. D. Glynn, Lancaster
Green	L. E. Creasy, Monroe	J. H. Bristow, Monroe
Green Lake–Waushara	A. A. Beck, Wautoma	L. J. Seward, Berlin
Iowa	S. B. Marshall, Hollandale	(Not reported)
Jefferson	W. S. Waite, Watertown	G. E. Eck, Lake Mills
Juneau	C. A. Vogel, Elroy	A. R. Kaufman, Mauston
Kenosha	G. C. Schulte, Kenosha	W. C. Stewart, Kenosha
La Crosse	A. H. Gundersen, La Crosse	E. E. Gallagher, La Crosse
Lafayette	R. B. Quinn, Darlington	(Not reported)
Langlade	W. P. Curran, Antigo	C. E. Zellmer, Antigo
Lincoln	F. C. Lane, Merrill	R. G. Baker, Tomahawk
Manitowoc	E. C. Cary, Reedsville	T. H. Rees, Manitowoc
Marathon	J. F. Smith, Wausau	E. E. Flemming, Wausau
Marinette–Florence	J. W. Boren, Marinette	A. T. Nadeau, Marinette
Milwaukee	J. O. Dieterle, Milwaukee	B. J. Birk, Milwaukee
	C. W. Eberbach, Milwaukee	E. A. Brzezinski, Milwaukee
	Charles Fidler, Milwaukee	S. J. Darling, Milwaukee
	R. E. Galasinski, Milwaukee	G. S. Flaherty, South Milwaukee
	J. L. Garvey, Milwaukee	P. J. Niland, Milwaukee
	L. W. Hipke, Milwaukee	P. E. Oberbreckling, Milwaukee
	Irwin Schulz, Milwaukee	E. D. Schwade, Milwaukee
	L. M. Wieder, Milwaukee	C. M. Schoen, Milwaukee
	J. C. Griffith, Milwaukee	R. A. Toepfer, West Allis
	A. R. Langjahr, Milwaukee	Bernard Krueger, Cudahy
	H. O. McMahon, Milwaukee	D. F. Pierce, Hales Corners
	J. W. Smith, Milwaukee	W. J. Scollard, Milwaukee
	W. F. Grotjan, Milwaukee	S. E. Biller, Milwaukee
Monroe	A. R. Bell, Tomah	G. C. Devine, Ontario
Oconto	J. S. Dougherty, Suring	C. R. Kwapy, Oconto
Oneida–Vilas	W. S. Bump, Rhinelander	I. E. Schiek, Rhinelander
Outagamie	C. D. Neidhold, Appleton	D. M. Gallaher, Appleton
Pierce–St. Croix	A. E. McMahon, Glenwood City	O. H. Anderson, Plum City
Polk	L. O. Simenstad, Osceola	W. B. Cornwall, Amery
Portage	A. G. Dunn, Stevens Point	M. G. Rice, Stevens Point
Price–Taylor	J. D. Leahy, Park Falls	H. B. Norviel, Phillips
Racine	R. M. Kurten, Racine	T. C. Hemmingsen, Racine
Richland	W. C. Edwards, Richland Center	George Parke, Viola
Rock	W. A. Munn, Janesville	W. T. Clark, Janesville
	H. E. Kasten, Beloit	H. A. Raube, Beloit
Rusk	L. M. Lundmark, Ladysmith	W. F. O'Connor, Ladysmith
Sauk	A. C. Edwards, Baraboo	M. F. Huth, Baraboo
Shawano	A. A. Cantwell, Shawano	F. L. Litzen, Gresham
Sheboygan	C. J. Weber, Sheboygan	A. C. Radloff, Plymouth
Trempealeau–Jackson–Buffalo	R. L. Alvarez, Galesville	M. O. Bachhuber, Alma
Vernon	W. M. Trowbridge, Viroqua	W. H. Remer, Chaseburg
Walworth	E. D. Sorenson, Elkhorn	C. J. Brady, Lake Geneva
Washington–Ozaukee	J. G. Hoffmann, Hartford	O. J. Hurth, Cedarburg
Waukesha	J. C. Hassall, Oconomowoc	R. E. Davies, Waukesha
Waupaca	J. H. Murphy, Clintonville	R. K. Irvine, Manawa
Winnebago	A. G. Koehler, Oshkosh	J. P. Canavan, Neenah
Wood	K. H. Doege, Marshfield	F. X. Pomainville, Wis. Rapids

FLOOR PLAN AND KEY TO EXHIBITS . . .



KEY TO SCIENTIFIC EXHIBITS

(See detailed description of these exhibits, page 636)

Booth No.	Title	Exhibitor
1— 4	Cooperative Medical and Engineering Effort in Industrial Health	E. G. Meiter, Ph. D., Industrial Hygiene Department, Employers Mutuals; E. L. Belknap, O. A. Sander and Norbert Enzer, Milwaukee; Mr. W. A. Vollmer, Milwaukee.
5	Health for Industry by Industry	Committee on Healthful Working Conditions, National Association of Manufacturers.
6	Sick Absenteeism Recording	P. A. Neal, National Institute of Health, United States Public Health Service.
7— 8	Artificial Air for Use by Pressure Workers	Edgar End, Department of Physiology, Marquette University School of Medicine.
9	Milkers' Nodules	F. T. Becker, Duluth, Minnesota.
10	Wisconsin Rheumatism Assn.	M. C. Borman, Milwaukee.
11—12	Diseases of the Thyroid Gland	Arnold S. Jackson, Madison.
13—15	The Pneumoconioses	American Medical Association.
16	Industrial Health in Medical Practice	Council on Industrial Health, American Medical Association.
17—19	Industrial Health Service in Wisconsin	Wisconsin State Board of Health, and Industrial Commission of Wis.
20	Lead Absorption and Intoxication in Everyday Life	G. H. Hansmann, and M. C. Perry, M. A., Columbia Hospital.
21—22	Tuberculosis in Industry	Wisconsin Anti-Tuberculosis Association.
23	Malaria in the Experimental Laboratory	Harry Beckman, and R. K. Ota, Marquette University School of Medicine.
24	A Health Program for Industry Based on a Modern School Hygiene Plan as Seen Through the Eyes of a Village Health Commissioner	E. B. Gute, Commissioner of Health, Whitefish Bay and Fox Point.
25	Human Convalescent Serum Center	Milwaukee Convalescent Serum Center, Columbia Hospital, M. A. Hardgrove.
26	The Diabetic Child	Milwaukee Children's Hospital, G. F. Kelly, and Nell Clausen, Dietician.
27—28	Highway Accidents and Alcohol	Committee on Safety on Public Highways.
29	Vital Statistics	Wisconsin State Board of Health
30	Maternal and Child Health	Wisconsin State Board of Health
A	The Premature Infant Feeding and Nursing Bureau, Inc.	Medical Society of Milwaukee County, James O. Kelley, Executive Secretary
B	Medical Library Service	University of Wisconsin Medical School, Gladys Ramsey, Lihrarian.
C	Testicular Deficiency	Walter M. Kearns, Milwaukee
D	Oxygen in Aviation and Medicine	W. M. Boothby, W. R. Lovelace, etc., Mayo Foundation, Rochester, Minn.

KEY TO TECHNICAL EXHIBITS

BOOTH 1

GENERAL ELECTRIC X-RAY CORPORATION

Chicago Milwaukee

X-RAY EQUIPMENT

From the G-E Office-Portable Diagnostic Unit Up to the Million Volt Equipment For Roentgen Therapy.

BOOTH 2

PHYSICIANS AND HOSPITALS SUPPLY COMPANY

412 South Sixth Street

MINNEAPOLIS, MINNESOTA

Dependable Supplies for the Physician and Hospital

BOOTH 3

ROEMER DRUG COMPANY

Wholesale Drugs and Surgical Instruments

HOSPITAL AND PHYSICIANS SUPPLIES
LABORATORY EQUIPMENT

606 N. Broadway Milwaukee, Wisconsin

BOOTH 4

ARTHUR H. NEUMANN, INC.

Surgical Instruments, Supplies and Equipment For

Physicians, Surgeons and Hospitals

4733 West North Avenue

MILWAUKEE, WISCONSIN

BOOTH 5

The Coca-Cola Company

ATLANTA, GEORGIA

"The Pause That Refreshes"

BOOTH 6

UNITED STATES HOSPITAL SUPPLY COMPANY

906 Marquette Avenue

MINNEAPOLIS, MINNESOTA

Surgical and Hospital Supplies and Equipment

BOOTH 7

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Manufacturers of

HORLICK'S

THE ORIGINAL MALTED MILK

Racine, Wisconsin

BOOTH 8

KREMERS-URBAN CO.

Pharmaceutical Chemists

141 West Vine Street

MILWAUKEE, WISCONSIN

BOOTH 9

SMITH, KLINE AND FRENCH LABORATORIES

105 North Fifth Street

PHILADELPHIA, PENNSYLVANIA

Pharmaceuticals and Biologicals

BOOTH 10

V. MUELLER & CO.

Surgeons Instruments

HOSPITAL EQUIPMENT & SUPPLIES

Ogden Ave., Van Buren & Honore Sts.

CHICAGO

BOOTH 11

BARD-PARKER COMPANY, INC.

DANBURY, CONNECTICUT

Detachable Blade Knife, Renewable Edge Scissors, Surgical Instruments

BOOTH 12

SCANLAN-MORRIS COMPANY

1902 East Johnson Street

MADISON, WISCONSIN

Manufacturers of

Hospital Sterilizers and Furniture

BOOTH 13

THE C. V. MOSBY COMPANY

Medical Publishers

3523-25 Pine Boulevard

ST. LOUIS

Publishers of Medical and Scientific Books

BOOTH 14

WESTINGHOUSE X-RAY COMPANY, INC.

LONG ISLAND, NEW YORK

Manufacturers of the most modern x-ray apparatus for both diagnostic and therapeutic purposes

BOOTH 15

S. H. CAMP & COMPANY

Surgical Belts, Binders
Orthopedic Braces
Maternity and
Convalescing Supports

Brassieres and
Breast Supports
Supporting
Combinations

JACKSON, MICHIGAN

BOOTH 16

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610 North 119th Street

Milwaukee, Wisconsin

Exclusive Manufacturers of

ALPINE SUN LAMP, KROMAYER LAMP, SOLLUX LAMP

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CARNATION COMPANY

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CARNATION MILK—

"from Contented Cows"

A Safe Milk For Children

BOOTH 19

E. R. SQUIBB & SONS

MANUFACTURING CHEMISTS
TO THE MEDICAL PROFESSION SINCE 1858

SQUIBB BUILDING

745 Fifth Avenue, New York

BOOTH 20

HURLEY X-RAY COMPANY

X-RAY and PHYSICAL THERAPY EQUIPMENT

Exclusive Distributors

Picker-Waite X-Ray Corporation
The Burdick Corporation

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MILWAUKEE, WISCONSIN

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LEDERLE LABORATORIES

INCORPORATED

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New York

CHICAGO BRANCH
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Dependable Pharmaceutical and Biological Products for Physicians

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"57 Varieties"

PITTSBURGH, PA., U.S.A.

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Established 1860

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AND SUPPLIES

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M & R Dietetic Laboratories, Inc.
585 Cleveland Avenue
COLUMBUS, OHIO

Dietetic Products for Both Normal and
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Petrolagar Laboratories
INCORPORATED
8134 McCormick Boulevard
Chicago, U.S.A.

Petrolagar available at all pharmacies
in five types

BOOTH 24

PARKE, DAVIS COMPANY
Home Offices and Laboratories
DETROIT, MICHIGAN

Pharmaceuticals and Biologicals

BOOTH 29

ELI LILLY AND COMPANY
Indianapolis, U. S. A.

PHARMACEUTICALS AND BIOLOGICALS

BOOTH 25

MEAD JOHNSON & CO.
Evansville, Indiana

FEEDING AIDS FOR THE INFANT AND CHILD

BOOTH 30

W. B. SAUNDERS COMPANY
West Washington Square
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Publishers of Medical and Scientific Books

BOOTH 26

E. H. KARRER COMPANY
Manufacturers-Dealers-Importers
Drugs and Pharmaceutical Specialties
Physician's and Hospital Supplies
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MILWAUKEE, WISCONSIN
Branch store at 523 State St., Madison
Telephone: Fairchild 6740

BOOTH 31

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Publishers Since 1792
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Books: General, School and College,
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BOOTH 32

MELLIN'S FOOD COMPANY OF NORTH AMERICA

BOSTON, MASSACHUSETTS

Mellin's Food
For Infants and Invalids
Originated by G. Mellin, 1866

Mellin's Food is favorably known throughout the world as a scientific modifier of milk for infant feeding

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MEDICAL PROTECTIVE COMPANY

OF FORT WAYNE, INDIANA

WHEATON, ILLINOIS

Professional Protection Exclusively since 1899

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INCORPORATED

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Philadelphia

BOOTH 39

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Pharmaceuticals of merit for the physician

170 Varick Street

NEW YORK CITY, NEW YORK

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PET MILK SALES CORPORATION

ST. LOUIS, MISSOURI

Irradiated Pet Milk
For Infant Feeding and General Dietary Practice

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STAMFORD, CONNECTICUT

Aolan, Aquaphor, Basis Soap, Collapsules, Elastoplast, Mediplast, Nivea Products

BOOTH 36

THE MENNEN COMPANY

NEWARK, N. J., U.S.A.

MENNEN'S ANTISEPTIC BABY OIL
TOILET PREPARATIONS OF QUALITY

BOOTH 41

Zimmer Manufacturing Company

WARSAW, INDIANA

Manufacturers of a Complete Line of Fracture Equipment and Other Surgical Supplies

BOOTH 37

U. S. Standard Products Company

WOODWORTH, WISCONSIN

Biologicals, Ampules and Glandular Products of Highest Quality and Purity

BOOTH 42

THE BORDEN COMPANY

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NEW YORK

Biolac
Dryco
Special Dryco
Beta Lactose
Klim
Merrell-Soule Products

Borden's Irradiated Evaporated Milks

BOOTH 43 and 44

The Kelley-Koett Mfg. Co., Inc.

Creators, Designers and Manufacturers of High Grade X-Ray Equipment Since 1900

Covington, Ky., U.S.A.

2327 West Fond du Lac Avenue
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BOOTH 45

WHITE LABORATORIES, Inc.

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Supplying the Medical Profession with Vitamin Preparations for Use in Both Normal and Special Diets

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RELIABLE PHARMACEUTICAL SERVICE

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The Lakeside Laboratories, Inc.

"MANUFACTURERS TO THE MEDICAL PROFESSION EXCLUSIVELY"

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PHILIP MORRIS & CO., LTD.

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IMPORTERS AND MANUFACTURERS OF HIGHEST GRADES CIGARETTES

BOOTH 51

H. G. FISCHER & CO.

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BOOTH 52

GERBER PRODUCTS COMPANY

FREMONT, MICHIGAN

GERBER FOODS
For Infant and Child Feeding

When You Attend The Annual Meeting Of The State Medical Society Be Sure To Visit The Technical Exhibits!

Physical Examinations of Industrial Workers

By PAUL A. BREHM, M. D.
Supervisor, Industrial Hygiene Unit
State Board of Health, Madison

A PROGRAM of pre-employment physical examinations and periodic reexaminations of workers in all types of industries was recently proposed in Wisconsin.*

This program is of great importance to the practicing physician and for that reason he should become thoroughly familiar with the procedures of the examination and their significance as they apply to the applicant's job or proper placement. It is not the intent here to interpret physical findings that deviate from the so-called normal. The evaluation of the physical fitness of an industrial worker must rest upon the clinical judgment of the examining physician. Such examination must not be taken lightly, because the physician is passing judgment on one who desires to become a wage earner or to continue in that capacity. The utmost care must be exercised in physical examinations of industrial workers to enable the examining physician to render an honest and accurate opinion in every individual case.

Important Features in Examination

Occupational and medical history. — In making a physical examination, perhaps one of the most important features is a detailed and accurate occupational history. The past jobs and exact occupations should be noted in their order along with the duration of each. This is significant from the standpoint of past environmental exposure and has a direct bearing on any similar exposures which are contemplated at the time of the examination or in the future. Occupational exposures, on the other hand, are valuable guides in the actual examination for the purpose of determining any signs or symptoms of ill effects resulting from such exposures.

A medical history is necessary in any physical examination. In the case of industrial workers, a history of respiratory diseases is important, particularly pertaining to tuberculous infection or exposure. The medical history should include diseases that are related to employment where exposures to environmental conditions must be taken into consideration during the ensuing examination. Any diseases or disabilities which may influence the safety of the employe or his co-employes should be determined, as, for example, epilepsy.

If the applicant for a position is a prospective employe, the exact occupation should be designated. This will serve as a guide for subsequent reexaminations in the event that the occupation is a potentially hazardous one. In the case of an old employe, it is necessary to record the exact occupation and the length of time he was employed. Again, in this regard, potentially hazardous working conditions should be kept in mind by the examining physician.

The present complaints of the applicant may be indications of ill health and should serve as guides during the examination. Substantial loss of weight in any individual,

* Wisconsin Physical Examination Program, Industrial Commission of Wisconsin, 1939.

FORMS TO BE AVAILABLE

As a special service to its members, the State Medical Society of Wisconsin will announce at the annual meeting registration desk, and in the October issue of The Journal, the availability of the standard approved forms for physical examination of industrial workers, as adopted by the Wisconsin Industrial Commission and as modified by that Commission to include a clause recommended by the State Medical Society providing for physician's release of confidential information. These forms will be available in pads bearing the name and address of the physician who orders them.

Order your blanks at the annual meeting registration desk or from the announcement sheets in the October issue of The Journal.

especially over a short period of time, should receive consideration, particularly from the standpoint of active tuberculosis.

Vision and hearing.—The test for vision is a very essential portion of a routine examination, notably where an occupation entails potential accident hazards. The examining physician must exercise judgment in cases of defective vision, depending upon the degree of impairment and the occupation of the employe.

Defective hearing is likewise significant as it is related to employment and specifically as it applies to occupations in which defects of this function would render the applicant unsafe, as well as those in the immediate vicinity.

Foci of infection. — The examination of the teeth should be carefully made to detect possible foci of infection or other conditions calling for dental care. In the examination of the throat, it is important to note disease of the tonsils, especially from the standpoint of foci of infection, as well as a predisposing factor to frequent upper respiratory infection.

Heart, chest, abdomen.—Careful examination of the heart is indicated in all individuals, chiefly those engaged in strenuous occupations. Abnormalities of the heart in such occupations may mean the safety of several individuals. The interpretation of blood pressure findings must receive careful consideration by the examining physician. An elevated blood pressure associated with either heart or kidney damage or both is significant in any occupation that calls for physical strain or one that may endanger the safety of others. Slight elevations of blood pressure unassociated with other pathological findings may be no more indicative than mere nervous tension on the part of the applicant during the time of examination.

Examination of chest and lungs is essential in detecting signs of disease, mainly tuberculosis, or indications of other chronic diseases as related to hazardous occupations. Some employers do not include x-ray studies of the chest in a routine examination and, in this event, the examining physician must exercise special caution in his conduct of the chest examination. Similar caution is indicated, too, in the case of other employers, and in particular in those plants where there is no specific pulmonary hazard, who, instead of providing for the approved procedure of making a flat x-ray plate of the chest for study, prefer, in order to lower examination costs, to have the physician conduct either a fluoroscopic examination or do tuberculin tests, limiting x-ray study to the positive reactors.

The abdomen may disclose signs of pathological conditions which may influence the health of the employe or his proper placement. In occupations where exposure to materials such as solvents may result in liver damage, the examination should emphasize this region. Additional diagnostic procedures in such cases may be indicated. Hernias of all types should be carefully detected because of their importance in jobs calling for any physical strain.

Back, skin, extremities.—Careful examination of the back should be made on all employes, principally those engaged in strenuous work. The range of motion and function should be taken into consideration. Evidence of disease or deformity must be weighed in the light of the physical requirements necessary for a particular occupation. The inattention devoted to this region may result in confusion and miscarriage of justice in the event of a future compensation claim.

The skin of the entire body should be examined to detect evidence of any existing lesions. The presence of skin lesions is influential in the placement of an applicant in an occupation where dermatitis may result from exposure to materials incident to the manufacturing process.

Extremities should be examined for any evidence of muscle or nerve impairment. Arthritic changes of joints and limitations of motion call for exercise of the physician's judgment as to whether the functional capacity is sufficient for a particular job. Examination of the reflexes should include more

than merely an elicitation of the knee jerk —they should be sufficiently complete to detect signs of dysfunction. The ill effects from occupational exposures to some toxic substances may be manifest in abnormal reflex actions and it is necessary for the physician to bear this fact in mind while examining an employe with a known exposure of this kind.

Varicose veins should be noted in regard to their degree and location and considered from the aspect of their influence on various types of jobs which might aggravate the condition or result in prolonged disability in the event of an accidental injury.

Enlarged glands, elevated temperature.— Glandular enlargement, particularly lymph and thyroid, should be given careful study to determine any ill effects upon the general health and efficiency of the worker.

Any elevation of temperature should always call for an explanation.

Laboratory Tests

By means of a Tallqvist hemoglobin determination and a quick cover-glass smear an adequate indication may be obtained regarding the condition of the blood. Abnormal findings by means of these two tests should be followed by a more detailed blood examination.

Albumin and sugar tests of the urine are sufficient for the purpose of routine examinations. The finding of either albumin or sugar in the urine is an indication for observation by the applicant's physician.

Blood should be taken for the diagnosis of syphilis. The importance of this diagnostic procedure for industrial workers cannot be over emphasized. Syphilis in the infectious stages should exclude an employe from work until adequate treatment has rendered him noninfectious. The only other reason for exclusion of a syphilitic person from employment is involvement of the central nervous system to the extent that the safety of the individual and his coworkers is imperiled.

X-ray films of the chest, in the course of a physical examination of industrial workers, are necessary for the accurate diagnosis of tuberculous lesions and should be taken, if possible, without regard to occupational exposure. The exclusion of a worker with active tuberculosis from contact with other employes in a work room area is sufficient justification for the additional cost involved on the part of any industry. The diagnostic value of x-ray films in tuberculosis control is dependent upon the qualifications of the clinicians making the interpretations.

Abnormal findings in the course of a physical examination may indicate that special procedures are necessary. If these are made, the results should be recorded on the examination form. Sputum tests and blood sedimentation rates are not made in a routine examination unless questionable findings indicate their necessity. Also, in certain industries where specific hazards are encountered, it may be necessary to employ special diagnostic technic, as, for example, careful examination of the blood in those individuals who may be exposed to lead compounds.

The duties of the examining physicians in making the above examinations do not cease at the end of a careful investigation or the reporting of the results of the examination to the employer or the employe. Rather, it should be one of the primary duties of a physician, when called upon by an industry to examine the workmen, to acquaint himself thoroughly with the manufacturing processes in that plant. He should know the physical requirements of the jobs and the materials to which the workers are exposed and he should know the ill effects which might result from exposure to excessive concentrations of such materials. Only by means of such a working knowledge can any examining physician be on the alert for early manifestations of diseases arising in the course of employment and be able to render a just opinion as to the employability or placement of the individual.

A NEW JOURNAL FEATURE APPEARS ON PAGE 787

Enduring Character

Sixty-four years—time to train succeeding crops of young men in Lilly traditions—time to establish a solid foundation on a policy that is strikingly like the Golden Rule.

EXTRALIN

(LIVER-STOMACH CONCENTRATE, LILLY)

'Extralin' provides the antipernicious-anemia principle in a highly concentrated form for oral use. With 'Extralin' the blood count may be maintained at normal levels with the least amount of inconvenience to the patient. Nine to twelve pulvules daily constitute an average maintenance dose.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES • INDIANAPOLIS, INDIANA, U. S. A.

Estimation of Disabilities Pamphlet and 1940 Edition of Wisconsin's Open Panel Well Received

IMMEDIATELY upon release of the special pamphlet to the entire membership on the estimation of disabilities under the Wisconsin workmen's compensation act, extensive demands were made upon the Society's office by insurance companies, attorneys and others, for copies of this pamphlet.

Almost simultaneously with the distribution of the pamphlet on estimation of disabilities, the Society placed in the hands of all of the stock and mutual insurance companies who were members of the American Mutual Alliance or the Association of Casualty and Surety Executives, the 1940 edition of the workmen's compensation panel prepared under the open panel agreement with those two insurance company associations.

Many comments were received on both the pamphlet on estimation of disabilities and the workmen's compensation panel. A few of the comments are reproduced below:

HARDWARE MUTUAL CASUALTY COMPANY
Stevens Point, Wisconsin

We are in receipt of a copy of your third edition of the Workmen's Compensation Panel as prepared by your society. Since this action was undertaken between representatives of your society and insurance carriers, I have heard many favorable comments made among labor representatives with reference to this liberalization of the medical provisions of the Wisconsin Law.

Since entering into this voluntary agreement between the carriers and the State Medical Society, I have heard no complaints from anyone directly affected by this procedure. On the other hand, there have been several favorable comments from both employers and employes. From our own experience with the gentlemen's agreement, we should like to see a continuation of the present relationship.

I have just come in possession of a pamphlet relating to the estimating of permanent disabilities, published by your society under date of June 15, 1940. While I have not as yet had an opportunity to study the contents of this pamphlet in detail, I am satisfied from a cursory observation thereof, that it will result in considerable benefit not only to the medical profession but to insurance carriers and, perhaps, eliminate several complaints insofar as injured workers are concerned with reference to absurd estimates of disability. I am certain that the information contained in this pamphlet will be of considerable benefit to the many doctors throughout the state and will better equip them to make their estimates of permanent disability conform more closely to the standards which have been adopted by the commission. I intend reading the contents of this pamphlet in detail before many days roll by. I am wondering if it would be possible for you to send us five or six copies of this pamphlet.

Yours very truly,
R. G. KNUTSON,
Assistant Claims Manager.

THE TRAVELERS
Milwaukee, Wisconsin

I had occasion yesterday to examine casually a pamphlet issued by your Society under date of June 15, 1940 on Estimation of Disabilities in Workmen's Compensation cases. It impressed me as a splendid piece of literature for distribution among the members of your Society, and the Doctor in whose possession I found it prized it quite highly.

I certainly would appreciate being the possessor of a copy and, if there are a few extra copies to spare, can assure you they would be appreciated by my office associates.

Yours very truly,
E. E. LANGWORTHY,
Adjuster.

EMPLOYERS MUTUAL LIABILITY INSURANCE COMPANY OF WISCONSIN
Wausau, Wisconsin

My congratulations on that splendid job which was done in getting out that little pamphlet on the compensation law. It ought to go a long ways in helping our medical men in this state appreciate the compensation problems better.

Yours very truly,
B. E. KUECHLE,
Vice-President and Claim Manager.

MASSACHUSETTS BONDING AND INSURANCE COMPANY
Boston, Massachusetts
Milwaukee, Wisconsin

I wish to state that we have used the open panel for the past year with satisfactory results.

We are glad to cooperate in this matter and we have advised our assureds to make use of the open panel so that injured employees will have free choice in the selection of medical attention.

Yours very truly,
I. H. RATHKAMP,
Adjuster.

Noah Webster might have written his definition of research with Parke-Davis in mind

Research is diligent, protracted investigation, especially for the purpose of adding to human knowledge.— N. Webster

Could the hundred and more research workers at the Parke-Davis Laboratories assemble around a great table to discuss the scope of medical research, they might talk in terms of those grueling jungle experiences, now a half century past, to seek out and add new drugs to the medical armamentarium. Or possibly their discussion would concern the brilliant work of wresting from the posterior lobe of the pituitary gland the secret of its two hormones. Or perhaps the protracted studies that led to the introduction of Meningococcus Antitoxin, which has reduced mortality from meningitis by more than half . . . all Parke-Davis research projects "for the purpose of adding to human knowledge."

As Webster defined research, so has Parke, Davis & Company followed through since those days in the early '70's when we inaugurated a definite program of pharmaceutical investigation so that "Medicine may make the life of the individual a longer and safer journey."

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Divisions of PARKE-DAVIS RESEARCH LABORATORIES: Pharmacy · Pharmacology · Botany · Organic Chemistry · Nutritional Chemistry · Analytical Chemistry · Microanalytical Chemistry · Physical Chemistry · Biochemistry · Immunochemistry · Endocrinology · Physiology · Histology · Hematology · Allergy · Bacteriology · Pathology · Immunology · Serology · Mycology

SECURITY MUTUAL CASUALTY COMPANY

Chicago

We acknowledge your form letter of July 18th with Wisconsin Workmen's Compensation Panel of 1940, for which we thank you.

In regard to the third paragraph of your letter wish to advise that we have complied with the requirement, that is, we have furnished all of our assureds with lists of the doctors in the county in which the assured is located, so they may post this panel in a conspicuous place and the employes may choose the doctor they wish to render treatment.

Yours respectfully,
SECURITY MUTUAL CASUALTY COMPANY.

INDEMNITY INSURANCE COMPANY OF NORTH AMERICA, PHILADELPHIA

Chicago, Illinois

We have for acknowledgment and thank you for your communication of July 27th.

We look forward to receiving a copy of this year's panel, together with a bulletin which you are attaching.

The panel which has previously been forwarded to us has been of utmost value. We have used it in each instance when the occasion arose. The panel is very compact and it is easy to refer to any area desired.

Very truly yours,
LESTER A. WHITE.

LUMBERMEN'S MUTUAL CASUALTY COMPANY

Chicago, U.S.A.

My attention has just been called to a pamphlet published by your society on the "Wisconsin Workmen's Compensation Act—Estimation of Disabilities." Would it be possible for you to send me about twenty copies of this pamphlet, so that I may distribute it to our Wisconsin claim representatives, and for the use of our Home Office men supervising Wisconsin claims.

I would appreciate it very much if you will place my name upon your mailing list for any like material you publish in the future. Thank you for this courtesy.

Sincerely,
R. E. HOWE,
Second Vice-President.

THE JOURNAL BOOKSHELF

BOOKS RECEIVED FOR REVIEW

Simplified Diabetic Manual; with 163 International Recipes (American, Jewish, French, German, Italian, Armenian, etc.). By Abraham Rudy, M.D., associate physician and chief of the diabetic clinic, Beth Israel Hospital, Boston; instructor in medicine, Tufts College Medical School; consultant in diabetes, Jewish Memorial Hospital, Roxbury, Mass. and Jewish Tuberculosis Sanatorium, Rutland, Mass. Cloth. Price, $2. Pp. 216, illustrated. New York: M. Barrows & Company, Inc., 1940.

Modern Dermatology and Syphilology. By S. William Becker, M.D., associate professor of dermatology and syphilology, Kuppenheimer Foundation, University of Chicago, and Maximillian E. Obermayer, M.D., assistant professor of dermatology and syphilology, Kuppenheimer Foundation, University of Chicago. Cloth. Price, $12. Pp. 871, with 461 illustrations in the text and 32 full color plates. Philadelphia: J. B. Lippincott Company, 1940.

Synopsis of the Principles of Surgery. By Jacob K. Berman, A.B., M.D., F.A.C.S., assistant professor of surgery, Indiana University School of Medicine, Indianapolis. Cloth. Price, $5 Pp. 615, with 274 illustrations. St. Louis: The C. V. Mosby Company, 1940.

The Diagnosis and Treatment of Pulmonary Tuberculosis. By John B. Hawes, 2d, M.D., late president of the Boston Tuberculosis Association, and Moses J. Stone. M.D., assistant professor of medicine, Boston University School of Medicine. Ed. 2, revised by Dr. Moses J. Stone. Cloth. Price, $2.75. Pp. 260 with 75 illustrations. Philadelphia: Lea & Febiger, 1940.

Dermatologic Treatment in General Practice. By Marion B. Sulzberger, M.D., assistant clinical professor of dermatology and syphilology, New York Postgraduate Medical School and Hospital, Columbia University, and Jack Wolf, M.D., attending dermatologist and syphilologist, New York Postgraduate Medical School and Hospital. New York City. Cloth. Price, $4.50 postpaid. Pp. 675 with 65 illustrations. Chicago: Year Book Publishers, 1940.

Principles of Hematology. By Russell L. Haden, M.A., M.D., chief of the medical division of the Cleveland Clinic, Cleveland. Ed. 2, thoroughly revised. Cloth. Price, $4.50. Pp. 362, illustrated with 321 engravings on 167 figures, including 173 original photomicrographs and 100 original charts and drawings and a colored plate. Philadelphia: Lea & Febiger, 1940.

Endocrine Therapy in General Practice. By E. L. Sevringhaus, M.D., F.A.C.P., professor of medicine, University of Wisconsin, Madison. Ed. 3, enlarged and completely revised. Cloth. Price, $2.75 postpaid. Pp. 238, with 49 illustrations. Chicago: Year Book Publishers, 1940.

Gynecological and Obstetrical Pathology; with Clinical and Endocrine Relations. By Emil Novak, A.B., M.D., D.Sc. (Hon. Dublin) F.A.C.S., associate in gynecology, Johns Hopkins Medical School; gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore, etc. Cloth. Pp. 496 with 427 illustrations. Philadelphia: W. B. Saunders Company, 1940.

The Emperor's Itch; the Legend Concerning Napoleon's Affliction with Scabies. By Reuben Friedman, M.D., assistant professor of dermatology and

BRIEF HISTORICAL NOTES

ND PABLUM

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f "pap" and "panada," there had
nutritive quality of cereals for
y for their carbohydrate content.

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syphilology, Temple University School of Medicine, Philadelphia. Cloth. Price, $1.50. Pp. 82, illustrated. New York: Froben Press, 1940.

Medical Nursing. By Edgar Hull, M.D., F.A.C.P., clinical professor of medicine, Louisiana State University School of Medicine, visiting physician, Charity Hospital of Louisiana at New Orleans; Christine Wright, R.N., B.S.; and Ann B. Eyl, B.S. Cloth. Price, $3.50. Pp. 588, with 168 illustrations, including 11 color plates. Philadelphia: F. A. Davis Company, 1940.

Clinical Methods: A Guide to the Practical Study of Medicine. By Sir Robert Hutchison, Bart., M.D., LL.D., F.R.C.P., consulting physician to the London Hospital and to the Hospital for Sick Children, president of the Royal College of Physicians, and Donald Hunter, M.D., F.R.C.P., physician to the London Hospital. Ed. 11. Cloth. Price, $5. Pp. 622, illustrated. New York: Paul B. Hoeber, Inc., 1940.

Physical Diagnosis. By William Nance Anderson, B.SC., M.D., associate clinical professor of medicine in the University of Southern California School of Medicine, Los Angeles, California. Cloth. Price, $4.75. Pp. 424, illustrated with 92 engravings. Philadelphia: Lea & Febiger, 1940.

Pharmacology and Therapeutics. By Arthur R. Cushny, M.A., M.D., Ll.D., F.R.S., late professor of materia medica and pharmacology in the University of Edinburgh, thoroughly revised by C. W. Edmunds, A.B., M.D., professor of materia medica and therapeutics in the University of Michigan, Ann Arbor, Michigan, and J. A. Gunn, M.D., D.Sc., F.R.C.P., professor of pharmacology in the University of Oxford, Oxford, England. Ed. 12. Cloth Price, $6.50. Pp. 852, illustrated with 66 engravings. Philadelphia: Lea & Febiger, 1940.

The Virus; Life's Enemy. By Kenneth M. Smith, F.R.S. Cloth. Price, $2. Pp. 176, illustrated. Cambridge: At the University Press; New York: The MacMillan Company, 1940.

Applied Pharmacology. By Hugh Alister McGuigan, Ph.D., M.D., F.A.C.P., professor of pharmacology and therapeutics, University of Illinois, College of Medicine. Cloth. Price, $9. Pp. 914, illustrated. St. Louis: The C. V. Mosby Company, 1940.

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BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Principles of Surgical Care: Shock and Other Problems. By Alfred Blalock, M.D., professor of surgery, Vanderbilt University School of Medicine, Nashville, Tenn. Cloth. Price, $4.50. Pp. 325, illustrated. St. Louis: The C. V. Mosby Company, 1940.

This monograph contains the material presented by Dr. Alfred Blaloch at the 19th series of Beaumont Lectures for 1940 under the sponsorship of the Wayne County Medical Society of Detroit, Michigan. The introductory chapter begins by quoting Lord Moynihan "Modern aseptic surgery has made the operation safe for the patient. It is now the aim of surgery to make the patient safe for the operation." This idea is the basis for the monograph and throughout the volume the care of the patient, both preoperatively and postoperatively, is stressed, with particular emphasis on disorders of the circulatory system, shock and peripheral circulatory failure. In addition there is a chapter on anesthesia and anesthetic agents. In this chapter Dr. Blaloch lists the various commonly used anesthetic agents and presents his evaluation of them under five headings: first, with regard to anoxia; second, explosive qualities; third, controllability of administration and elimination; fourth, toxicity; and fifth, adequacy of anesthesia for operative purposes. Under explosive qualities he states that cyclopropane and ethylene are highly explosive and that Jones of the Bureau of Mines indicates that there is not a great deal of difference in explosive qualities of cyclopropane, ethylene and ether when combined with oxygen. Nevertheless, he states that he has recently stopped using cyclopropane because of fear of explosion, which seems rather inconsistent if he continues to use ether and ethylene.

Other chapters discuss surgical technic and the treatment of wounds, metabolic and nutritional dis-

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turbances, with emphasis on acid-base disorders, diabetes, nephritis and hypertension and endocrine disorders. The final three chapters deal with pulmonary, abdominal and other common postoperative complications.

In general, this monograph is a rehash of the present knowledge on shock and pre- and postoperative care with little new information present. For the individual who is unable to keep up with current literature, this represents an opportunity to review the subject of surgical care and treatment as interpreted by the author. It is a worthwhile volume and is highly recommended to those interested in treatment of surgical patients. K. E. L.

An Introduction to Biochemistry. By William Robert Fearon, M.A., Sc.D., M.B. F.I.C., fellow of Trinity College, Dublin, member of the Royal Irish Academy. Ed. 2. Cloth. Price, $3.75. Pp. 475. St. Louis: The C. V. Mosby Company, 1940.

This is an unexpectedly comprehensive presentation of the subject in a small volume. Because of the large coverage and brevity of treatment it is perhaps really a compendium. The explanatory schematic presentation of every topic, that lends itself to such presentation, adds much to the clarity and makes the smallness of the book possible. The treatment is primarily didactic but the viewpoint presented is carefully selected and quite up to date. References at the ends of the chapters open up the enormous literature of authoritative treatment of the various subjects, in which any other recognized viewpoints, as well as those presented, are given in detail. The typography and binding are attractive. It is a book that can be held in one hand, a feature that appeals to this reviewer. E. J. W.

A Method of Anatomy; Descriptive and Deductive. By J. C. Boileau Grant, professor of anatomy in the University of Toronto. Ed. 2. Cloth. Price, $6. Pp. 704, illustrated. Baltimore: The Williams & Wilkins Company, 1940.

The title of Dr. Grant's book is well chosen. It is not the usual textbook of human anatomy. A necessary amount of description makes up the bulk of the book, but both the text and the line drawings emphasize the deductive and interpretative approach to the subject. This approach plus an informal well written text makes the book instructive and very readable. It is not a reference book and probably will prove most useful as collateral reading, both for the medical student and the practitioner who find pure descriptive anatomy necessary if somewhat tedious.

A general description and interpretation of the systems of the body and more than a hundred new illustrations feature this second edition of this interesting work. O. A. M.

Synopsis of Obstetrics. By Jennings C. Litzenberg, M.D., F.A.C.S., professor emeritus of obstetrics and gynecology, University of Minnesota Medical School, Minneapolis. Cloth. Price, $4.50. Pp. 394, with 157 illustrations including 5 in color. St. Louis: The C. V. Mosby Company, 1940.

This is, as the title states, a synopsis of obstetrics. It is a brief concise outline of the subject matter with adequate illustrations. It should be used to refresh one's memory of obstetrics in preparation for state board or other examinations, but should not be recommended as a reference book or textbook for medical students. M. J. T.

A Handbook for Dissectors. By J. C. Boileau Grant and H. A. Cates, University of Toronto. Cloth. Price, $2.50. Pp. 239. Baltimore: The Williams and Wilkins Company, 1940.

"A concise guide to the orderly and consecutive display of the structures of the human body to be used as a companion to *A Method of Anatomy*—", thus the publisher's notice accurately characterizes the book. There are almost no illustrations, those being in the companion text. In spite of its brevity it has the one fault inherent in all dissectors, that is the tendency to prevent the development of initiative and judgment on the part of the student. As examples of this absurdly meticulous supervision one may quote twice from page 197 on the dissection of the ear. Concerning the use of a gouge—"If the ulnar border of the hand holding the gouge is rested on the specimen, the gouge can be controlled when struck with the mallet." And again concerning removal of the ear drum— "—and carefully pick it out by placing one blade of the forceps on each side of it." By and large, however, the handbook, like Professor Grant's text, is full of extremely useful information and original points of view. H. W. M.

Clinical Diabetes Mellitus and Hyperinsulinism. By Russell M. Wilder, M.D., Ph.D., F.A.C.P., professor and chief of the department of medicine, the Mayo Foundation for Medical Education and Research, University of Minnesota; head of the section on metabolism therapy, division of medicine, The Mayo Clinic, Rochester, Minnesota. Cloth. Price, $6. Pp. 459, with 19 illustrations. Philadelphia: W. B. Saunders Company, 1940.

This volume is produced by one of the most experienced and successful clinicians in the management of diabetes in America. It is well written, accurate, up-to-date and comprehensive. The style makes it possible to find out either the clinical general principles desired or to go back to the authoritative research work which gives the evidence on which conclusions are based. The volume is large enough to comprehend the needs of the man who is a special student of diabetes. The work is recommended for every hospital library where diabetics are being treated. Every clinician who sees any considerable number of diabetics will want to have it immediately available. E. L. S.

Minor Surgery. By Frederick Christopher, S.B., M.D., F.A.C.S., associate professor of surgery at Northwestern University Medical School, Chicago; chief surgeon at Evanston (Ill.) Hospital. With a foreword by Allen B. Kanavel, M.D., F.A.C.S. Ed.

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4, reset. Cloth. Price $10. Pp. 990 with 639 illustrations. Philadelphia: W. B. Saunders Company, 1940.

The four editions that this volume has undergone in the past ten years attest to its popularity with surgeons, general practitioners, teachers, and students. Unfortunately, as the author points out in his preface, the title of Minor Surgery is somewhat of a misnomer since many of the operations described are of a major nature. Inasmuch as a suitable title could not be evolved, which would describe the bulk of surgical conditions commonly seen in practice, the title, Minor Surgery, was used.

In the past decade there has been a strong feeling that many contributors, and rightly so, are necessary in order to write a good surgical volume dealing with many subjects. Because of his wide experience and his teaching ability, Christopher has, without collaboration, masterfully dealt with these fundamental and commonly met surgical conditions. He advantageously uses the basic sciences to rationalize treatment and complications.

This edition omits many technics previously described since they have been proven to have little or no value. On the other hand, new methods are brought up although the reader is always given the technics found best in the author's hands, and the reader is constantly referred to the latest literature. In fact, the chapters on infected and clean wounds, burns, and circulatory disturbances have practically been rewritten because of the many innovations brought up in the past few years.

Last but not least, the reviewer feels that all those interested in surgery should read the chapters on minor surgical technic and on interns. A. R. C.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1939 with the Comments That Have Appeared in The Journal. Cloth. Price, $1. Pp. 205, with 5 illustrations. Chicago: American Medical Association, 1940.

Only seven of the thirty-five reports listed in this annual collected report are of the familiar "Not Acceptable" or condemnatory type. Two reports announce omission of products from N.N.R., one being off the market. The remainder, far superior in bulk as well as in number, are concerned with educational and constructive considerations. This trend has been noticeable in recent years; it reflects the great predominance of the constructive over what may be called the destructive side of the Council's work of promoting rational therapeutics.

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Any member of the profession in good standing who did not receive a program, please write the Managing-Director and one will be mailed.

COMPREHENSIVE SCIENTIFIC AND TECHNICAL EXHIBIT. SPECIAL ENTERTAINMENT FOR THE LADIES

The educational reports touch three fields on which lie the front lines of present day therapeutics progress—chemotherapeutics, endocrines and vitamins. Two reports on sulfapyridine deal with the status and Council acceptance of commercial brands. The report on Neoprontosil recognizes that term as the Winthrop Chemical Company's proprietary name for 4-sulfonamide benzene-2-azo-1-hydroxy-7-acetylamino naphthalene-3:6-disodium sulfonate, and azosulfamide as the nonproprietary name for the same substance. The articles on Dilantin Sodium, Sobisminol Mass and Sobisminol Solution are status reports which accompanied the descriptions of accepted brands, a type of article increasingly used by the Council. Dilantin sodium is the new drug used in the treatment of epilepsy and has been accepted by the Council with carefully stated limitations for its use; sobisminol mass and sobisminol solution are new soluble bismuth preparations for use in the treatment of syphilis; they are noteworthy in that sobisminol mass has been shown to be effective when used orally. The reports on racéphedrine and nikethamide deal with nomenclature; these terms are recognized as nonproprietary names for racemic ephedrine (the sulfate and hydrochloride are also recognized) and pyridine-β-carboxylic acid diethylamide respectively; the latter was introduced into medicine under the proprietary name Coramine-Ciba and was the subject of a preliminary report by the Council in 1929 (THE JOURNAL, June 1, 1929, p. 1837).

The status report on questions concerning vitamins compiled by the Cooperative Committee on Vitamins of the Councils on Pharmacy and Chemistry and on Foods is becoming an almost annual event, awaited for the revisions of the "Allowable Claims" found acceptable for the various vitamins. This year's revisions are not extensive but the report is noteworthy for the reemphasis of the Council's stand on the subject of vitamins and vitamin mixtures. Alas, the Councils' is but one clear, authoritative voice of rationality in today's whirlwind of polyvitamin and polyvitamin-mineral absurdities foisted on the gullible public by astute and sophisticated advertising technic. The preliminary and supplementary reports by Snell and by Snell and Butt on the new principle for active hemorrhagic diathesis known as "vitamin K" are timely and noteworthy.

The leadership of the Council in matters of endocrine therapeutics and nomenclature is well sustained by such reports as Chorionic Gonadotropin, Assay Standards for Chorionic Gonadotropin, Stilbestrol and the Present Status of Testosterone Propionate: Three Brands, Perandren, Oreton and Neo-Hombreol Not Acceptable for N.N.R. No brand of any of these has been accepted and these reports are excellent justification of the Council's intelligent and well informed conservatism in this as in other matters.

Three "special" reports are worthy of mention. One is the warning report on the dosages of intraurethral injection of solutions of local anesthetics, a reaffirmative strengthening of previous Council pronouncements. One is the Council statement Manganese in the Treatment of Dermatologic Disorders, which is buttressed by the conclusive and well documented paper of Dr. Maurice Sullivan, considered and sponsored by the Council. The third is the Study of the Promiscuous Use of the Barbiturates, Their Use in Suicides, a paper by Dr. W. E. Hambourger based on a review of medical literature and study of vital statistics. This study was authorized by the Board of Trustees of the A.M.A. and will be followed by other papers dealing with other aspects of the problem.

The present annual volume of Council reports is somewhat larger than usual and somewhat above the average issue in interest.

New and Nonofficial Remedies, 1940, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1940. Cloth. Price, postpaid, $1.50. Pp. 656–LXVIII. Chicago: American Medical Association, 1940.

Each year a revised list of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association as of January first is published in book form under the title of "New and Nonofficial Remedies." The book contains the descriptions of acceptable proprietary substances and their preparations, proprietary mixtures if they have originality or other important qualities, important nonproprietary nonofficial articles, simple pharmaceutical preparations, and other articles which require retention in the book.

A list of articles and brands accepted by the Council, but not described, is included in the book to cover simple preparations or mixtures of official articles (U.S.P. or N.F.) marketed under descriptive, nonproprietary names for which only established claims are made. Diagnostic reagents which are not used in or on the human body, and protein diagnostic preparations are not included in New and Nonofficial Remedies unless the determination of the status of these products by the Council has been requested by the distributor: If such products are found to be marketed in accordance with the Council's rules, they may be included in the list of undescribed, but acceptable articles.

New and Nonofficial Remedies is a practical and condensed text of pharmacology and therapeutics; it contains scientifically elaborated standards for all accepted nonofficial drugs; its Index to Distributors is a list of manufacturers, a large number of whose products have met the Council's high standards; its Bibliographical Index is a storehouse of references to reports which have been made mainly on unaccepted and unacceptable drugs; its prefatory material contains the Council's "Rules," a time-tested and reliable set of basic principles for the furtherance of scientific and rational medicine.

A supplement to the annual volume of New and Nonofficial Remedies is published twice a year to

bring up to date such current revisions and additions as have been necessary since its last publication. Every product included in the book is subject to the official rules of the Council. The comments to rules are changed occasionally by way of clarifying interpretation to insure fair consideration of all submitted preparations as new standards are recognized. Such constant and critical consideration of its contents provides the physician with a valuable reference list of acceptable new preparations on which to base his selection for use in treatment according to the established current practices of the profession.

The 1940 New and Nonofficial Remedies, of course, contains the revisions which appeared in the supplements for the 1939 edition, and continues the plan of grouping together articles having similar composition or action under a general discussion. These discussions have undergone considerable revision in the 1940 edition. Further revision of statements regarding the actions, uses, dosage, composition, purity, identity, strength or physical properties of many of the articles has also been necessary in some cases. Noteworthy revisions are those of the chapter on Liver and Stomach Preparations, radically rewritten and including a statement of requirements suggested by findings of the Anti-Anemia Preparations Advisory Board of the U. S. Pharmacopeia; the subsection Tuberculins, entirely rewritten to conform to newer knowledge in this field; and the chapter Allergenic Protein Preparations, the name of which has been changed to Allergenic Preparations. Minor but relatively important revisions are found in the articles: Bismuth Compounds, Serums and Vaccines, and Vitamins and Vitamin Preparations for Prophylactic and Therapeutic Use.

The indices of the new volume of New and Nonofficial Remedies are of the same order and plan as in previous editions. A general index lists accepted articles, including those not described. This is followed by an index to distributors in which appear all the Council accepted articles listed under their respective manufacturers. Finally, a bibliographical index is added for listing proprietary and unofficial articles not included in N.N.R. This includes references to the Council publications concerning each such article as has appeared in The Journal of the A.M.A., Reports of the Council on Pharmacy and Chemistry, Propaganda for Reform, Vol. 1 and 2, or Reports of the A.M.A. Chemical Laboratory.

KARAYA AND RELATED AS CAUSES OF ATOPY

(Continued from page 736)

paring fluid extracts it is important to realize that sterilization by Berkefeld or Seitz filtration is virtually impossible because of the gummy character of the material. It is necessary to sterilize by heating the solution at 70 degrees for one hour on three consecutive days. This procedure, while undoubtedly diminishing the potency of the antigen, still leaves sufficient active principle for most purposes.

Intravenous injections of these gum solutions are not devoid of danger in spite of the fact that they are poor in nitrogen.

Summary

Allergy to vegetable gums, such as karaya, acacia and tragacanth, are not rare. Because of the wide use of these materials in cosmetics, foods, pastes, constipation remedies and many other products, many more instances of this type of allergy will undoubtedly be found. While this discussion deals only with patients demonstrated to be sensitive to these gums, the possibility of other water soluble gums in industry being a source of allergy must not be overlooked.

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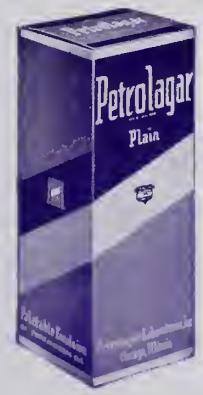

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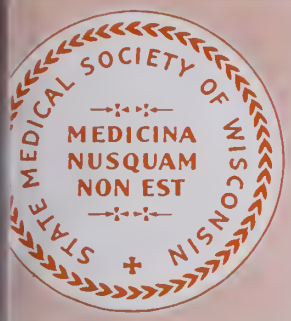

The Wisconsin Medical Journal

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nney Building

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STUDIES IN THE AVITAMINOSES

This page is the tenth of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the September 14 issue of The Journal of the American Medical Association.

Photograph courtesy of C. P. Rhoads, M. D., Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City.

The Glossitis of PELLAGRA

The glossitis of pellagra is usually among the early symptoms. It is manifested initially by hyperesthesia, which frequently develops before objective signs. As the deficiency state becomes more pronounced, desquamation of the superficial epithelium gives the tongue a beefy red, smooth, dry appearance. During desquamation, secondary infection with Vincent's organisms or Monilia frequently occurs, producing a thick white or yellow coating which ultimately is shed. The tongue becomes swollen, and fissures and aphthous ulcers develop on its surface. The inflammatory process spreads to the buccal mucosa, the gums, the lips and the pharynx, producing superficial ulcerations in these areas.

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The skin lesions of pellagra are considered one of the diagnostic signs; they are seen on the hands, neck, under the breasts, on the perineum, and on the legs. They usually are bilateral and are sharply demarcated from the surrounding normal skin. At first the involved area becomes erythematous and tender, resembling a mild sunburn. The skin is tense and swollen; itching and burning may be severe. At this stage vesicles or bullae frequently appear. After a period of weeks or months, the edema subsides, the erythema disappears, and the involved skin may assume a more normal appearance. Residual pigmentation persists, however, especially about the hair follicles.

Illustration courtesy of Henry Field, Jr., University of Michigan Medical School, Ann Arbor.

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THE WISCONSIN MEDICAL JOURNAL

Volume XXXIX
Number 10

MADISON, WISCONSIN, OCTOBER, 1940

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THE TRACE ELEMENTS IN BIOLOGICAL MATERIALS

● Students of nutrition recognize a total of some thirteen inorganic elements either as essential to humans or, in our present state of knowledge, as probably desirable for complete nutrition. For certain of these elements—definitely proven to be essential—reasonable estimates of the daily human requirements have been made. In addition, the distribution in common foods of minerals, especially those essential minerals most apt to be deficient in the diet, is well understood. Certainly, enough information appears to be at hand to insure an optimal supply for the individual of these essential or desirable elements through modern diet planning.

However, for many years it has been known that traces of elements, other than those known to be essential, may be present in animal and plant tissues (1, 2). Improvements in analytical techniques have been made and greater precautions observed in the handling of the materials used for analysis in studies reported within recent years. The results of these newer investigations have only served to confirm the fact observed in the older studies, namely, that "trace elements" may be present in biological materials, including mammalian tissues, along with the other elements recognized or accepted as essential in nutrition.

A fairly complete list of the trace elements includes silicon, aluminum, fluorine, nickel, arsenic, bromine, rubidium, barium, and selenium. The persistent occurrence of these elements in foods and in animal tissues logically raises two questions. First, are these elements essential in human nutrition, and second, assuming them to be essential, how might an adequate supply be obtained.

For the first of these two questions, there is as yet no conclusive answer (1, 2). Study of the possible part the trace elements may play in normal body functions comprises one of the frontiers of nutritional research. The fact that the trace elements are more or less consistently present in animal tissues is not necessarily conclusive proof of their essential character in nutrition; further research alone must decide that point.

The second of the above questions can be answered somewhat indirectly. It is not illogical to believe that we already recognize as essential those elements whose serious deficiency in the diet may produce the most serious irregularities in the human organism. Further, as stated above, the distribution of the known essential minerals in foods is well understood and by modern diet planning an adequate supply of these nutrients should be readily attained. It is not meant to imply that all of the trace elements are without significance in human nutrition, or that one essential nutrient is more important than another. Instead, it is intended to suggest that the distribution of all elements in foods is probably such that a protective diet—calculated to supply optimal amounts of all known essential minerals—should also supply the proper amounts of any unknown essential elements, as well.

Thus, the need for following the modern pattern of diet formulation is further indicated. The most practical means of insuring the needed quantities of all essential nutrients—recognized or as yet undiscovered—is to plan the ration according to the concepts and teachings of the modern science of nutrition. In pursuing the modern diet pattern (2), commercially canned foods should prove both valuable and convenient.

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REFERENCES

1. 1939. Mineral Metabolism, Alfred T. Shohl, Reinhold, New York.

2. 1939. Food and Life, Yearbook of Agriculture, U. S. Dept. Agri., U. S. Government Printing Office, Washington, D. C.

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**Medical Record, Aug. 21, 1940*

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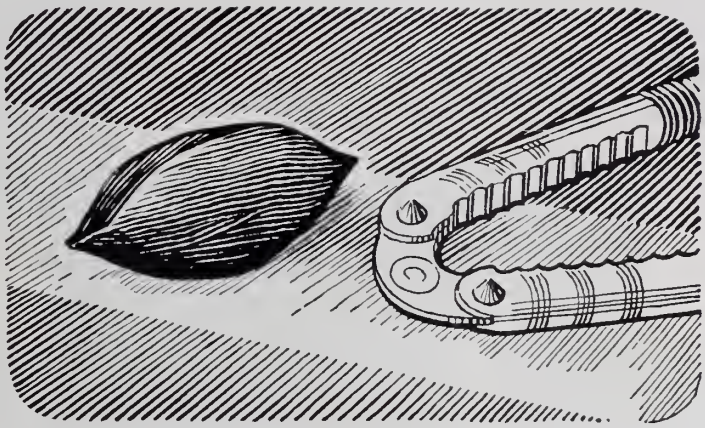

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THE WISCONSIN MEDICAL JOURNAL

VOLUME XXXIX, NO. 10 Copyright, 1940, by The State Medical Society of Wisconsin OCTOBER, 1940

Presidential Address*

By RALPH P. SPROULE, M. D.
Milwaukee

TO US, the physicians of this state and nation, a great challenge has gone forth. The issue is: are we to preserve our individual rights as physicians to practice, or do we become in fact or in reality employes of the state? That this step will not come as bluntly as this, there is no question. However, certain insidious forces are at work by indirection which, undefeated, will lead ultimately to this goal.

This is not our problem alone, but applies to the dental, legal, and other allied professions as well. Paradoxically enough, the legal profession, which makes up one-third of the membership of all the legislative bodies in the country, unless frustrated, may aid in passing the laws which will bring about state medicine, and, may I add, parenthetically, eliminate a great part of their private law practice as well. So I call on these professions, grouped for the purpose of my remarks, to properly appraise the present picture, not for private gain but in the interests of the people of this country. If the welfare of the people is preserved, the rewards to the professions will follow without further direction.

If we are able to project ourselves out into mental space for a brief moment and look at our economic problems as a whole, certain facts are outstanding.

We, as a people, are in a state of economic "flux;" I would almost say — confusion. Which philosophies you and I are to live under we do not know. Although great economists seem to be in the ascendency for the moment, ultimately the fundamental economic principles, such, for example, as the "law of supply and demand," must again come into their own. Historians probably will look upon this age as a great transition period. Political mountebanks will have had a chance in this period to use the people of this nation as guinea pigs.

When a country issues gold bonds and states that the bonds will be paid off in kind, then repudiates that obligation—

When a country issues gold certificates for the money the man carries around in his pocket and states it will be redeemed in gold, and yet it cannot be so redeemed—

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When a government stirs up class hatred—

When a government invades the field of private enterprise and yet has failed miserably in the management of public enterprise—

When a government has failed to provide properly a defense mechanism for 130,000 people, although billions have been spent in that direction during the last seven years—

When, after some months of recognizing this and a war has been going on one year that from its start threatened to involve us, we are still not agreed on what form that defense should take—

When we ship scrap iron to Japan,—2,027,000 tons in 1939,—for profit, to kill and maim a million defenseless Chinese and then expound our purity to European nations—

When a government, after ten years of direction under master professional crackpots finds itself $50,000,000 in debt, and the fundamental problems for which the indebtedness was incurred are the same . . .

* Presented at the 99th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1940.

I might go on at much greater length, but the above picture is sufficient to bring forth the confusion in the public mind. We as a people are tense just now and a little worried. We must think a little for ourselves instead of letting the Great White Father in Washington and his delusionists do it for us. Paternalism must cease; the mature voter must loosen himself from his temporary false haven. He must put on long pants and be an honest force for the concepts of righteousness in human affairs and government as in his forefather's day. A half million physicians, dentists, lawyers, and allied professional groups can be quite a force in this regard.

In this confusion of philosophies of government it cannot be fair to presume the physician should escape entirely, if at all. Up to the present time he has kept aloof from politics, as such. His time has been employed in the care of the sick. He is known for his professional efforts and his scientific attainments. If he is outstanding in his work he has been rewarded by the respect of his fellow physicians and the kindly thoughts of benefited patients and their families. If he must enter governmental contests to fight for principles dear to him for thousands of years; if he must give up this time in the care of the sick to make out lengthy governmental red-tape reports, who but the sick will pay?

It must be admitted the doctor will get along, but the public actually must suffer. Perhaps along with the pains that organized business is experiencing and the individual sacrifices which must be made by John Q. Public if we are to get out of this mess, the physician will have to take a double dose as a citizen and as a physician.

Fundamentally, the doctor is a fine fellow. He is a good citizen; he is educated four years beyond the college graduate; he has been in school one year longer than the lawyer—four years beyond the commerce school graduate—one year beyond the doctor of philosophy and the doctor of science. In fact, there is only one who goes beyond him in years of intellectual training, and that is the Jesuit priest. Some of us may go off on tangents that extreme intellectual training brings. However, that does not mean we should fall for worn-out philosophies of medical care imported from a fallen Europe.

We have witnessed in the past year the fall of most of the countries of Europe,—the attempt of one country to survive the grasping tyranny of another. In these countries there have been bred the evils as well as the good of medical care of the low-income groups, hospital insurance, state medicine, etc. When these are presented to our people they are in new clothes; they are a novelty. In tinseled wrappings they can be made to appeal to the imagination of the voter. He appears to get something new for nothing. The voter should beware of diluted medical service as we know it to be in Europe, some of us first-hand. In this country it will be diluted by the politician, cut by the layman filing the reports, and all of them telling the physician what he can't do for his patients. And if we have further regimentation the then conceivably controlled press will fill the people's minds with the wonders of state medicine and the comparison of how "poor" our form of practice used to be.

You rugged individualists of medicine must fight back this collectivism banner which has been waved before many students of the last ten years. We have many forms of attack. Let it be made up from the cloth of America and not from the cheese-cloth of Russia. No branch of science has advanced more or faster in the history of the world than has medicine in America. Picture these improvements in my life-time in life-saving knowledge:

1. Diphtheria has become a rarity. In 1921 to 1925 patients were constantly intubated at our Isolation Hospital. Now, six months will go by without a single intubation in a community of 800,000 people.

2. When I was a boy diabetic patients did not have a chance. Today, insulin keeps them alive and happy for years.

3. Liver extract has done much for anemia.

4. The field of vitamin therapy has produced dramatic cures of eye, skin, and other nutritional disturbances.

5. A general practitioner will go two decades without seeing a case of typhoid fever.

6. Many dreaded types of streptococci have been conquered by sulfanilamide. The fatality from

meningitis has been reduced to as low as 22 per cent in some clinics.

7. Pneumonic deaths have been decreased with sulfapyridine and convalescent serum treatment.

These and many other achievements are products of the medium of the New World. They have been brought about under our present system of the practice of medicine. Can the citizenry of this country risk a change in the form of practice of medicine which has such a record? It would be as unthinkable as discharging the most respected manager who had built up the finest business in town. This is America, and, as one presidential candidate said in his acceptance speech, "Let us do it in the American way."

We are not so self-satisfied as to consider medical facilities beyond improvement. More illnesses can be prevented, health improved, and lives spared. But, as one writer has stated, "We must bear in mind the health problem so that a false picture is not created in the public mind leading to a hasty and emotional solution of the problem—to a solution that will do more harm than good."

There has been no exception to annual improvement in national health from 1932 to 1939. It is no accident that the United States should have

- The lowest death rate
- The lowest maternal mortality
- The lowest infant mortality
- The lowest tuberculosis mortality

in its entire history.

In 1900 the average American worker lost twenty-eight days because of illness. Today he loses only eight days a year, and, in Wisconsin, less than two and one-quarter days. This is at least five times better than England's best and not less than eight times better than Germany has ever done; yet both of these countries have the pattern of sickness care that propagandists now advocate for us. In this steadily improving record we have something to lose as well as to gain, says an editorial writer in the *Rocky Mountain Medical Journal.*

If we look at Germany and the totalitarian countries and at England under the panel system, where medicine is under political and lay control, we find medicine on a level far below ours. We find, also, for every doctor at work there is one bureaucrat or record-keeper to whom the patient must first go to get permission to have treatment, charged against the insurance funds. Doctors spend precious hours, that should be productive, filling out reports and certificates that patients were duly authorized and classified to be treated.

Under regimentation in Germany, *Readers' Digest* says:

Scarlet fever cases in 1933 were 78,830
Scarlet fever cases in 1937 were 117,544
Diphtheria cases in 1933 were 77,340
Diphtheria cases in 1937 were 146,733
Cases of sickness recorded in sickness bureaus rose 20.3 per cent between 1933 and 1936.
Dysentery has increased 300 per cent in six years.

Are we, the people of this country, to allow European-minded, copying economists to bring about such a state? Let us convince the people that political and lay control of medicine with all its implications can lead only to progressive deterioration.

It has been said by one writer that the two elemental human interests,—religion and medicine,—foster the case of the other fellow, and they are both now fighting for survival along with democracy. Perhaps we have been judged a little too coldly scientific. It might be well for us to aid in the fostering of the spiritual side of man and try to reverse the decadence of religion. The clergy could do the people a great service by aiding us to combat vicious propaganda over the radio, in one-sided magazine articles, and in screen presentations.

During the first six months of 1939, 13,000,000 people received United States government checks. That means that 40,000,000 are living directly off government pay: one-third of our population, not including the Army and Navy. If you, the physician—the arch individualist since Hippocrates time—cannot with energy meet this, be prepared to join the unhappy and unfortunate 13,000,000.

It has been aptly said that we are living in the golden age of medicine. We know that all is not what it should be in the distribution of the fruits of medicine. We all are created free and equal. We all remain free,

but not equal. Some always will have more than others. Many have enjoyed distributing it to those who have less. The middle man in this distribution has probably gone as far as he should. Our medical service, we admit, is not distributed in the completely Utopian way. Neither is coal or food or clothing or shelter. They never will be under any system.

We have attempted to improve our hospital staffs and keep them on a high standard. As a result, we are accused of being a "medical trust." Would the intelligent, public-spirited citizen like to go back twenty years? Today he looks with pride to his hospital, and letters of appreciation pour in to these institutions by the hundreds. The American College of Physicians, the American College of Surgeons, the American Medical Association have made these things possible.

I hope my remarks have awakened your zeal. Ours is a profession worth fighting for. In the era of our great scientific achievement let us not be discouraged, but carry on as united individualists. Let us unite our efforts in the common bond of our county organizations and our State Society, to the end that the poor patient as well as the more fortunate may continue to profit from our efforts. With this goal in mind medicine will again be restored to its former place of esteem. The politician will die, but medicine as our ancestors knew it will live on.

Let us dare to fight for the right as we know it.

Treatment of Upper Respiratory Tract Infections in Children*

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IT IS obviously impossible in a discussion such as this to cover all or even most methods of treating respiratory infections in children. It is my intention, therefore, even at the risk of seeming entirely too elementary, simply to describe in more or less detail some treatments that have proved reasonably successful in at least giving symptomatic relief and thus hastening recovery. In order to do this, I will follow, in some hypothetical cases, the progression of symptoms and the meeting of various indications as they arise.

The Drizzly Nasal Cold

First let us consider the all-too-familiar drizzly nasal cold. About the first question to be raised in the case of a patient with this condition is: "Shall he be kept in bed?" The answer, I believe, should be: "Yes, keep him in bed, if you can." In other words, our object is to secure extra rest for this patient. But if we put him to bed and he kicks and screams for hours on end, it is obvious that none of us are getting any rest, let alone any extra rest. Therefore it is sometimes necessary to have these children up and around part of the time in order to keep them quiet.

Now, as to the actual treatment, in the early stages—say the first two or three days—some antiseptic nose drops, such as 5 per cent argyrol or the less messy but equally effective neosilvol, are frequently of definite benefit. These drops should be given in moderation, that is, not more than three times a day. And, while we are on the subject, a few remarks about nose drops in general may be in order. The solutions used for this purpose are either primarily antiseptics, primarily vasoconstrictors, or mixtures of the two. In the early stages of infection, the invading organisms are probably nearer the surface and thus more easily reached by the antiseptic solutions while, in the later stages, the increased congestion, and consequent interference with ventilation of the nose, makes the vasoconstricting solutions of more value. There is another point about nose drops, however, that I feel is of some importance, and that is the question of oily versus watery solutions. My preference is decidedly for the watery solutions, for these reasons: First,

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the presence of oil on the nasal mucosa has a distinctly inhibiting effect on the normal ciliary action and so slows up one of the natural forces tending to promote drainage. This is not true of watery solutions. Secondly, if any of the solution is aspirated into the lungs it will be dislodged quite easily if it is watery, but the retention of oil in the lung, with consequent oil pneumonia, has been reported too frequently to be regarded lightly.

Even more important than the solution used is the technic of its use. If the head is simply tipped backward, any solution introduced into the nose will run back quickly into the pharynx merely moistening the floor of the nose as it goes. If the patient is lying flat on the back while the solution is instilled the result is about the same. Obviously, then, neither of our objectives, antisepsis or vasoconstriction, will be achieved by this method. However, if we have the patient lie on the back with the head hanging over the edge of the bed, we find that the head is then really upside down and our nose drops will flow into the middle and superior meatus and may even actually enter the antra. Then when the upright position is resumed the solution flows down over the turbinates but little if any reaches the pharynx. This method not only gives much better results in the nose, but it also greatly decreases the chances of aspirating the solution and frees the patient from the unpleasant effect of swallowing it.

So much, then, for nose drops. What else can we do for this child with the drizzly nose? The use of some form of aromatic oil or grease as a chest application is about as time-honored and popular a remedy as one can find. And while mere antiquity should not be taken as any criterion of efficiency, still it is hard to discard any treatment that has withstood the ravages of time as well as this one has. That any material applied to the chest wall can have any effect on the lungs simply because they lie within the chest wall does not quite make sense. There is another action of these materials, however, that comes a whole lot nearer to making sense. A good many years ago it was shown by McGuigan that if the fumes of menthol or camphor are bubbled through thick mucus, they have a distinctly liquefying effect on the mucus. Thus, if some of these aromatic materials are applied to the chest, there will be rather prolonged inhalation of their vapors with consequent improvement in nasal drainage. So, let's grease the youngster's chest with mentholatum, camphorated oil or some other aromatic material, and, to accentuate the production of fumes, let's cover the chest with an extra shirt or a soft towel pinned inside the night suit. Once or twice a day the chest should be sponged off with water or diluted alcohol and a new application made.

Another time-honored but unfortunately much neglected method of improving nasal drainage is the use of steam inhalations. According to Nesbit, the value of steam lies in relieving the nasal mucosa of the necessity of warming and humidifying the inspired air and considerable shrinkage of the mucosa takes place, thus permitting better aeration and better drainage. I believe that better results are obtained from intermittent, intensive steaming, with good room humidity maintained in the intervals, than from keeping a whole room soaking wet. There are, obviously, many methods of providing steam inhalations but the one I have found the simplest and most effective is that in which the tea kettle is boiling full speed on the kitchen stove so that it blows a heavy blast of steam into the room. The child then stands on a chair so that his face is in the column of steam but far enough away so as not to become too hot. The hair and front of his clothes should be covered with a towel because there is going to be enough steam to get them soaking wet during the five minutes he stands there. If he finds the steam too hot even at that distance, an open umbrella held over him and over the column of steam will give a very good concentration of steam but not quite so effective as the direct method. For those children who cannot be taken to the kitchen some form of bedside steamer must be provided. By placing a boiling kettle on an electric plate beside the bed, steam can be led to the child through a tube made of a rolled-up newspaper. For those children who persistently fight against the use of steam it may be necessary to make a tent by draping a sheet over an open umbrella or over the whole bed. And finally, on the steam prob-

lem, what shall we add to the water? I believe that it is really not necessary to add anything as our chief benefit comes from the warmth and moisture, and if we are using household utensils it seems rather pointless to mess them up with such solutions as compound tincture of benzoin, etc.

What shall we do in the general treatment of this little fellow with the drizzly nasal cold? In spite of the treatments described so far we will probably find him quite restless and a bit feverish. Under these conditions it is often remarkable how much temporary benefit is obtained from small, but not too small, doses of aspirin. It can be administered to any child if mixed with a little sugar and a few drops of water on a spoon. There is, of course, no specific action of aspirin, nor of any other drug for that matter, on these infections but by making him feel a little less "rotten" the child will rest very much better and thus be saved some unnecessary wear and tear.

In regard to diet, it is seldom necessary to do anything as the natural loss of appetite automatically reduces the food intake, which is about the only change advisable. The old dictum "stuff a cold and starve a fever" doesn't make sense anyhow and obviously goes on the rocks when the cold is accompanied by plenty of fever. Although I have never seen the dictum "pour a purge into every sick child," I am sure there must be one lurking about somewhere and I am also sure that it is just as out of place as the "stuff and starve" foolishness. But it is really amazing how prevalent the belief seems to be that whenever a child gets sick "it must be something he et," and that the first step in treatment is to "clean him out," forgetting entirely that his fever may be from tonsillitis or that his howling may be from an earache. So let me make this little pediatric plea at this time: No matter what *seems* to be the matter with the child, look him over completely anyhow. Many times something less obvious but more important will be found and the few extra minutes the examination takes are eminently worth while.

And now to follow this drizzly cold through some of the changing manifestations that may call for changes in treatment. As time goes on the nasal secretions become thicker and finally are definitely purulent. At this stage our antiseptic nose drops are not of much value but the vasoconstrictors frequently are of value. Also the aromatic greases or oils to the neck and chest and the steam inhalations should be continued. But in spite of these measures there is usually considerable difficulty in dislodging these tenacious secretions and it is at this time that the use of a nasal suction apparatus is of special benefit. This is a very simple form of treatment which I believe has not achieved anywhere near the popularity that its effectiveness and simplicity warrant. The elaborate electric pumps are, of course, very fine but not at all necessary, as perfectly good results can be obtained with the little water power, filter pump type that can be attached to almost any water faucet.

There are several points of considerable importance to be considered in the use of a suction pump if the best results are to be obtained:

(1) The strength of suction used must be enough to really pull the secretions out of the nose but not enough to cause pain. As a rule the effect of too much suction is to collapse the soft tissues of the nose and thus prevent air from leaving, while too little suction fails to pull out any secretions. No definite rule for judging the strength of suction to be used can be given as it varies considerably under different conditions, but in general one can say that it is best to begin with quite gentle pressure and increase as needed.

(2) The suction should be maintained for only two or three seconds at a time. This not only reassures the child that he is not going to have his nose pulled out by the roots but the changing pressures are more effective in moving thick secretions.

(3) The opposite nostril must be closed *after* the nasal tip is introduced. Otherwise the soft tissues will be drawn into the tip as it is introduced and plug it up.

(4) The pharynx must be closed off by elevating the soft palate as the pump is obviously unable to create negative pressure in the entire respiratory tract. In children who will cooperate this elevation of the palate is easily accomplished by having them repeat

"tick-tick-tick" several times. In children who will not cooperate there is usually violent enough vocal protest to close off the pharynx and make good suction possible in spite of them. It is the quiet, passive little non-cooperators, who will neither speak nor scream, that make the use of the pump impossible.

Another point about pumping is the use of some sort of vasoconstricting nose drops or steam inhalations, or both, before using the pump, thus assuring much more complete drainage. Any reasonably intelligent parent can be taught to use a nose pump effectively and by using it two or three times a day it is surprising what enormous quantities of secretion can be removed from a nose.

A further point about these noses with abundant, thick, purulent drainage is to remember that if the condition continues for as much as two weeks the infection has probably invaded the nasal sinuses. This simply means that our efforts at maintaining drainage by all these methods must be continued and even redoubled in order to prevent chronic sinus disease.

At this stage of the infection it is common to find cough developing or, if already present, increasing. In addition to the measures already described, which are usually quite helpful in controlling cough, I have only this to say: The younger the child and the earlier the stage of the cough, the simpler the remedy should be. Thus a simple syrup made by adding a few drops of lemon juice to a half teaspoonful of sugar or honey is frequently very soothing to the irritative coughs of infants and young children. Sedative mixtures are indicated when irritation increases, but obviously should not be pushed when there are bronchial secretions to be coughed out.

Otitis Media

Of the many complications that may arise during these infections the only one that I shall touch upon at this time is otitis media. And let me here repeat my plea for complete examination of sick children by reminding you that otitis very often develops silently and that unless you look for it you won't know it is there. Of course, with persistent pain babies will probably rub the ear and older children will complain of earache, but it is surprising how frequently one finds restlessness or disturbed sleep as the only symptom. What, then, are the findings in the ear drum that are important? Obviously, an inflamed drum will be red; but more important than this obvious change is the fact that a diseased drum may be almost normal in color. On close inspection it will be seen that the color is more of a dead white than the normal pearly gray, but when one is sort of galloping around the room trying to poke an otoscope into the ear of a badly frightened child there is quite a strong temptation to dismiss as normal any drum that is not red. So it should be remembered that the initial redness of the drum may be lost within twenty-four hours, but that if there is fluid in the middle ear the landmarks of the drum will be disturbed. Therefore, if it is possible to get only a quick look at an ear, first find the umbo and see if the drum drops away from it in the normal manner. A little point that is frequently of help in deciding about the tension in the middle ear is to watch a spot of light as it is reflected from a drop of moisture next to the drum. If this spot can be seen to pulsate, then one is justified in assuming that the middle ear is filled with fluid.

In spite of the occasional sporadic uprisings against them, I am convinced that good old phenol and glycerine ear drops have a real place in the early treatment of otitis media. A mixture of phenol (gr. 10) and glycerine (½ oz.) is certainly harmless to the tissues and yet very effective. These drops should, of course, be used warm and quite liberally; at least three times in the first hour and every two hours thereafter. During these first hours it is very seldom wise to open the ear drum even though it may be definitely bulging. So many of these acute conditions subside under treatment, or perhaps by themselves, that it is best to give them a chance before subjecting the child to the distress of a myringotomy.

What, then, are the indications for myringotomy? I believe that a partial list of them can be stated thus:

(1) A bulging drum that remains painful for six or eight hours.

(2) A bulging drum that becomes painful after a quiescent period that may be as long as thirty-six hours.

(3) A bulging drum that remains bulging and obviously thickened even though the child's general condition is improving. (In these cases the ear infection is probably unimportant as far as the child's general condition goes but the possible damage to the ossicles is quite important.)

(4) A bulging drum, even though painless, in a child who does not seem to be recovering as rapidly as he should.

Finally, I would like to say just a word as to the drug treatment of otitis. So many of these secondary invaders are streptococci that the administration of sulfanilamide is justified even without actual identification of the organism. The dosage should be regulated according to the apparent severity of the infection. That is, don't hesitate to use full doses in a very sick child, but where the infection is less severe begin with moderate dosage and increase if improvement is not satisfactory. In general it can be said that children tolerate the drug very well, and in this connection it is interesting to note that one frequently finds the tolerance for the drug proportional to the need for it. For example, I recall a 15 year old boy with a slight sore throat who showed distinct cyanosis after his third 5 grain dose, while a 1 year old boy with a positive blood culture showed no toxic symptoms on 60 grains a day.

Croup, Laryngitis, Tonsillitis

And now let us consider briefly some other manifestations of these upper respiratory infections. Here is a familiar story: A child is put to bed apparently perfectly well and then, sometime after midnight, wakes up with a very hoarse cough and considerable inspiratory and expiratory stridor; in other words, a typical attack of croup. Here the use of steam inhalations, hot compresses to the larynx, and hot drinks are very effective but antipyrene given in doses of 1 grain per year of age up to 5 grains will be found to act almost as a specific. It may be repeated every three to four hours if needed and because of the notorious tendency for croup to recur, it should be given before bedtime for two to three nights even though there have been no symptoms during the day. If the symptoms do not follow the typical course by disappearing entirely during the day, then be on guard against the development of an obstructive laryngitis, or more correctly, laryngo-tracheo-bronchitis. These are always serious cases and many require tracheotomy. They are usually due to streptococcal invasion and hence treatment should be given with ample doses of sulfanilamide.

And here is another familiar story. A child is found to have a high fever and to be a bit knocked out but with nothing to account for the fever. So, disregarding grandmother's assertion that it is probably his teeth, we look him over and find a definite follicular tonsillitis. Just why it is that a child, even when old enough to tell what hurts, can have violent tonsillitis without pain when the same infection in you or me would make us believe we were harboring a red hot poker, I cannot explain. But the fact remains and is another argument in favor of examining all sick children. As a rule these and many other throat infections respond well to sulfanilamide.

In conclusion, may I repeat that I have made no attempt to cover all methods of treatment but simply to discuss some simple, important, and yet often neglected points in the treatment of respiratory infections in children.

A. M. A. MEDICAL PREPAREDNESS SURVEY 52 PER CENT COMPLETE

"On September 6 the Committee on Medical Preparedness (of the American Medical Association) had received 93,437 schedules from physicians throughout the United States and its outlying territories. This number represents 52 per cent of the 179,796 schedules which were mailed to physicians in July," *The Journal* of the Association reports in its Medical Preparedness Section for September 14.

"The response of physicians in different states showed a wide variation, from 83.2 per cent in Nebraska and 85.8 per cent in the Canal Zone to 38.5 per cent in New Mexico and 0.08 per cent in the Philippine Islands. Thirty-eight states returned more than 50 per cent of the questionnaires.

Gangrene in Diabetes*

By ARCHIBALD H. BEARD, M. D.
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I SHALL discuss in this paper a method of treatment for diabetic gangrene which has reduced mortality in the disease 50 per cent in both the University Hospitals of the University of Minnesota and the Minneapolis General Hospital. But, first, I should like to review certain physiologic and pathologic factors.

Physiologic, Pathologic Review

Arteriosclerosis accompanies old age; therefore, it is somewhat of a physiologic condition. It occurs ten to fifteen years earlier in the diabetic person than in the nondiabetic person; the prevention of premature arteriosclerosis in persons with diabetes is still an ideal to be reached.

The most generally accepted theory as to the cause of this disease is that of Aschoff. He believes that blood plasma over-saturated with lipoids predisposes to its development. Insulin has made it possible for the diabetic patient to live into the fifth, sixth and seventh decades. Consequently, arteriosclerotic complications have increased because of two factors; namely, the disease itself, and the greater age which diabetic individuals now attain.

There are many methods of determining the presence of arteriosclerosis in an individual. The oldest method of palpation of the arteries is uncertain but fairly satisfactory. Examination of the vessels of the fundi gives an excellent index of the amount of arterial disease, but no information as to the amount of lime salt deposits in the vessels. This can be determined only by means of x-ray study. However, one should not overlook the significance of such clinical findings as intermittent claudication, the presence or absence of pulsation of the vessels, and the lowering of the local temperature of an extremity, all of which are clinical aids in determining the deficiency of circulation.

The first stage in the development of arteriosclerosis is the appearance of plaques of yellowish, subendothelial streaks in the intima. On microscopic examination the thickening is found to be due to edema and to an increase of connective tissue in which lipoids are deposited. In diabetes the chief lipoid present is cholesterol. Gradually this deposit works into the outside of the vessel wall, and calcium replaces the cholesterol. In this way two conditions develop in the artery, first, a gradual restriction of the lumen due to the change in the intima, and, second, a deposit of calcium, which makes the vessel less elastic and more pipe-like in character. Diabetes shows its chief change in the intima; simple arteriosclerosis is apt to show only calcification without any marked restriction of the lumen.

It is interesting to note that there is a higher incidence of gangrene of the lower extremity and coronary sclerosis among diabetic patients than among nondiabetic ones of corresponding age. It is not known whether diabetes has any relation to calcification or fibrosis of the medial layer in the artery. However, thrombosis rarely occurs in the vessels of those with diabetes because of the fact that the lesion is principally on the arterial rather than the venous side. This is further evidence that the lesion in diabetic gangrene is due to the cutting off of nourishment to the tissue.

Clinically, the diabetic patient may have one or two types of gangrene, either the dry or the moist. Dry gangrene usually is present in uncomplicated arteriosclerosis without diabetes. This can be called the ischemic type of gangrene. Diabetic gangrene, however, usually is the moist type and is the result of infection superimposed on dying tissue. This type very often leads to generalized sepsis. I believe the high mortality found in this condition can be decreased by using the type of treatment to be described herein.

Author's Treatment and Its Basis

I shall not repeat the various causes of injury and the possible sources of infections in the extremities of the diabetic individual. Every physician has repeated instructions to diabetic patients time and again, stressing the danger of carelessness, restriction of the blood supply, ill-fitting shoes, and dirt.

The blood supply in the extremities gradually is reduced. As long as collateral circulation in the smaller vessels can take care of this decreased blood supply, gangrene does not occur. A state of equilibrium is set up in which there is a delicate balance between the supply and demand of these cells. In time the tissues or individual cells reach a hair-trigger mechanism whereby any change in either fluid or metabolism may result in gradual starvation due to improper blood supply. If, in addition to this, there is some superimposed change, as slight infection or increased pressure on the tissue, the delicate balance is upset. In this way diabetic gangrene first begins. Later infection in the dying tissue occurs, and gangrene rapidly spreads to other already impoverished cells. In a short time large areas become involved, and general sepsis rapidly develops. Therefore, if gradual readjustment of this delicate mechanism can be brought about before

* From the department of medicine, University of Minnesota Medical School. Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1940.

large areas are involved, there is a greater chance to decrease mortality rates. This can be best accomplished by the cooperation of the internist and the surgeon.

Because sepsis and inadequate blood supply develop early in diabetic gangrene, amputation has been the usual procedure. It is difficult for the surgeon to estimate the level to which the gangrene might spread. Early amputation is responsible for the high mortality because of the poor general condition of the patient. Gangrene is not the result of sudden decreased blood supply alone; it is also the result of a sudden increased need of metabolism in the cells themselves due to infection. With insulin's inability to complete its function (probably because of the fever present) and improper balance of fluid with dehydration, there is another loss of food to the tissues. Therefore, if the metabolic requirements can be decreased by the debridement of tissue and the elimination of the dead and infected parts, the blood supply will be adequate to take care of whatever remaining normal tissue is present. In that way amputation can be done at a later date with less risk to the patient.

It is important that the internist determine the patient's diabetic status immediately on admission to the hospital. This includes examinations to determine blood sugar levels, nitrogen balance, sodium chloride balance, anemia, and ketosis. During the first twenty-four to forty-eight hours in the hospital, the patient should be treated more as a medical problem than a surgical one. He needs insulin and fluid to counteract the dehydration usually present. An attempt should be made not to allow the blood sugar to fall too rapidly. The diabetic patient, as a rule, is elderly; consequently he is apt to have coronary changes and to develop cardiac complications if the blood sugar drops too fast or too low. The blood sugar usually cannot be controlled at a normal level with the infection that is present, but after twenty-four hours acidosis can be almost eliminated if enough saline and fluids are given in addition to the necessary amount of insulin. One must remember that insulin is not as effective during periods of dehydration.

After the acidosis is controlled the patient is ready for whatever immediate surgery is indicated. Pentothal anesthesia is used, and the infected or devitalized tissue is removed along with any bony structure that is exposed. The surgeon should not attempt to save an important structure. His main objective should be to remove the dead tissue down to a living base, leaving no pockets or over-hanging skin borders. Then the wound is covered with a cod liver oil dressing, and the patient continues under a medical regime. At the end of approximately twenty-four hours the general sepsis usually is improved to such an extent that the urinary sugar output is under control. At this time the patient's diet can be fairly liberal. The next procedure is to give the patient warm 3 per cent saline packs or baths at 100 F. The extremity should be immersed to at least the mid-calf unless this would have an ill effect on the patient's condition. The above treatment can be alternated with rest approximately every other hour during the day.

In this method, the diabetic patient with gangrene has a longer period in which to improve before serious surgery is undertaken. Usually after three to seven days the patient has very little fever, and any necessary amputation can be done at a higher level without the serious results that would have occurred had the amputation been done on the patient's entrance to the hospital. This treatment is not resorted to in an attempt to give the patient a lower or more superficial amputation; it is used primarily to take care of the emergency due to sepsis, fever and general dehydration that is present when the patient is admitted to the hospital. It is in accord with the belief that amputation should not be undertaken as an emergency measure, but that amputation should be resorted to as an elective procedure at a later date. As stated hereinbefore, this treatment has resulted in a 50 per cent drop in mortality in the University of Minnesota hospitals and the Minneapolis General Hospital.

Lymphogranuloma Venereum

Report of Thirty-Three Cases*

By A. G. SCHUTTE, M. D., and J. M. LUBITZ, M. D.
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THE purpose of this paper is the presentation of a series of cases of lymphogranuloma venereum in Wisconsin, to bring to the attention of Wisconsin practitioners the possibility of occurrence of the condition in any locality, and the presentation of salient clinical features of the disease, its diagnosis and treatment.

Lymphogranuloma venereum is a venereal disease caused by a filterable virus and acquired most often by venery. The initial lesion is usually genital, but may be extragenital. It is usually a small, painless, herpetiform or papular lesion occurring in the vagina, urethra, or on the external genitalia. It is commonly transient, but occasionally persists for several weeks.

Clinical Manifestations

In the male.—The onset of the disease in the male simulates that of an acute infection. Commonly, pains in the back and extremities, headache, anorexia, malaise, temperatures of from 100 to 104 F., and, occasionally, chills and night sweats comprise the subjective symptoms. Unilateral or bilateral inguinal lymphadenitis appears. Pain, swelling and tenderness of the affected areas increase as the glandular involvement progresses. The lymphadenitis usually results in multiple areas of suppuration and perforation. The symptoms persist from one to several weeks and the discharging inguinal sinuses heal slowly.

In the female.—In contradistinction to the acute symptoms accompanying the development of the bubo in the male, the onset and early development of lymphogranuloma venereum in the female usually proceed unnoticed, because of its common vaginal location, until the symptoms of developing or actual rectal stricture occur. Sometimes the development of rectal stricture is accompanied by a rectal discharge, with or without blood or pain. More often, the symptoms of severe, obstructive constipation, rectal abscess or perianal condylomata are the signs which first attract the attention of the patient. Again, the enlargement of one or both labia caused by elephantiasis, with or without ulceration or sinus formation, may be the initial warning sign. Any or all of the late manifestations of the disease may be present in one patient. The condition in the female is usually accompanied by secondary anemia and, in cases of severe stricture, by malnutrition and weight loss.

Rectal stricture.—In the female, the stricture is located in the lower rectum. Its lower limit is found by introducing the index finger slightly more than half its length. The stricture area feels like scar tissue. The rectal surface immediately below it is frequently irregular and ulcerated. The degree of stricture often prevents instrumentation and ordinarily does not admit the tip of the examining finger. X-ray study will demonstrate the extent and contour of the stricture. Many rectal strictures are associated with one or more fistulas, which have external openings in the perianal skin.

Diagnosis

The diagnosis of lymphogranuloma venereum has been greatly facilitated by the use of the Frei test. The test consists of the intradermal injection of 0.1 cc. of Frei antigen.† The reaction is positive when a reddened and swollen area, greater than 7 mm. in diameter, appears at the site of the

* Cases encountered in the proctologic clinic of Marquette University Medical School and the Milwaukee County General Hospital in the course of work undertaken primarily to determine the incidence of lymphogranuloma venereum in cases of inflammatory rectal stricture.

† In this study, the mouse brain antigen and control, manufactured by Lederle Laboratories, Inc., New York City, were used.

injection within forty-eight to seventy-two hours, and remains from one to several weeks as an elevated papule. Pigmentation of the skin at the site of a positive Frei reaction may remain for a year or more.

A history of ordinary or perverted sexual exposure can usually be elicited in cases of acute and chronic inguinal adenitis and in cases of extragenital lesions which are due to lymphogranuloma venereum.

The symptom of rectal bleeding or chronic constipation, particularly in the colored female, should suggest rectal examination for ulceration or stricture.

Late manifestations, such as elephantiasis of the external genitalia of the female, and occasionally of the male, are diagnostically significant. However, in all suspected cases, the Frei test acts as a specific aid to verify the diagnosis.

Chancroidal bubo can be distinguished from lymphogranuloma venereum by isolation of Ducrey's bacilli and the Ducrey skin test.

Identification of Donovan bodies by histologic study will eliminate the possibility of granuloma inguinale as the diagnosis.

Multiple fistulas of the inguinal and perianal skin, due to pyodermia, can be differentiated from lymphogranuloma venereum by the Frei test and the absence of other pathological manifestations of lymphogranuloma venereum.

Occasionally biopsy is necessary to distinguish rectal carcinoma from stricture, or condylomata from epithelioma of the external genitalia.

It should be remembered that the combination of posterior urethral stricture and rectal stricture can be caused by lymphogranuloma venereum.[1]

Treatment

No specific remedy is known for the treatment of lymphogranuloma venereum. The intradermal administration of Frei antigen, once or twice a week, and intravenous administration of antimony and potassium tartrate are of proven value. Reports from several sources[2,3,4] indicate a favorable response from the use of sulfanilamide in this disease. We have been favorably impressed by the results obtained from a limited experience with this drug.

In acute suppurating bubo, drainage by incision is usually indicated. Sulfanilamide appears to aid in the resolution and healing of acute bubo.

Inflammation and ulceration of the lower rectum, which is an early manifestation before actual rectal stricture develops, appears to improve on sulfanilamide therapy. However, only continued use of the drug and follow-up observation will determine whether this therapy will prevent the formation of rectal stricture or influence its course and complications after it is established.

The distressing local and intestinal obstructive symptoms, due to old rectal stricture, usually can be greatly alleviated by a low residue diet, mild laxatives and daily rectal irrigations. Colostomy should be done in cases in which the response to palliative measures is unfavorable, because colostomy invariably results in gratifying improvement

Fig. 1. Positive Frei reaction in female with rectal stricture.

Fig. 2. The vulva, in this patient, was excised electrosurgically to provide relief. Since the excision the patient has been married and given birth to a son.

of the general condition of the patient. Dilation of the rectal stricture is unpopular with patients and offers little relief.

Acute perianal abscess should be treated by incision.

Case Reports and General Findings

Of the thirty-three patients studied, sixteen were males (thirteen colored, three white), and seventeen were females (sixteen colored, one white). Fifty per cent of the males and 70 per cent of the females had syphilis.

One hundred per cent of the males had inguinal adenitis; one white male had rectal stricture and one colored male had elephantiasis of the scrotum and penis.

The average age of the females was 33 years. Rectal stricture, perianal condylomata and rectal fistula were present in 53 per cent of the females; 23 per cent had ulcerations of the rectal mucosa without stricture. Forty-two per cent of the females had vulvar elephantiasis; 17 per cent had inguinal adenitis.

Case 1.—C. P., a white male, aged 29 years, developed rectal soreness and pain several weeks following sodomy. He had personal knowledge that his partner to the act had had recent sexual contact with a colored female. The rectal distress was followed in several weeks by a left inguinal adenitis which later suppurated. Examination disclosed a left posterior rectal fistula with thickened and inflamed skin on the left side. There was a stricture at the anorectal juncture. The inflamed inguinal glands had several draining sinuses.

This case illustrates how rectal stricture in the male can be the result of primary inoculation of the anal canal or lower rectum with the virus of lymphogranuloma venereum.

Case 2.—R. F., a colored male, aged 26 years, entered Milwaukee County General Hospital with a temperature of 102 F., anorexia, headache and generalized body pains. He had been ill for ten days and was feeling progressively worse. There was a small healed lesion on the glans penis and

Fig. 3. (Same patient shown in fig. 2.) Three years after excision of vulva, showing condylomata and numerous fistulous openings.

bilateral lymphadenitis. The blood Wassermann test was negative, but the Frei test was strongly positive.

Sulfanilamide therapy was instituted and the patient's general condition returned to normal within two weeks. The inguinal adenitis subsided without suppuration and the glands were barely palpable after four weeks.

Public Health Aspects

There is no doubt about the infectious nature of the primary lesion of lymphogranuloma venereum, or that the disease is contracted by venery. The specific virus has been isolated[5,6,7] from the exudate and discharges of ulcerations, sinuses and fistulas commonly associated with the later lesions. Secondary infection of chronic open lesions is common. Whether the disease can be transmitted by contact in the later stages is not established. However, investigation of contacts of patients with early manifestations of the disease will result in identification of persons with infectious lesions. The morbidity of lymphogranuloma venereum in the female constitutes a serious health problem.

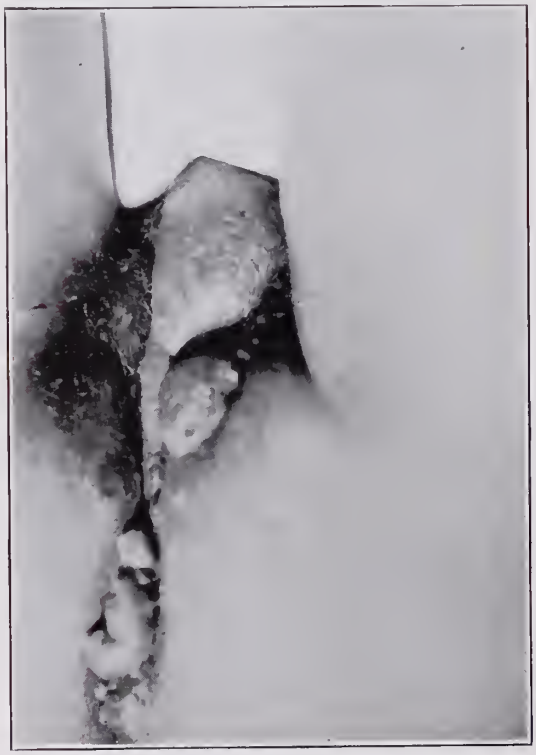

Fig. 4. Elephantiasis of left labium majorum and involvement of perineum and anus.

Summary

1. Lymphogranuloma venereum is a venereal disease caused by a filterable virus, usually manifested clinically in the male by a primary penile lesion, followed by suppurative inguinal lymphadenitis, and in the female by elephantiasis of the vulva, rectal stricture, condylomata and perianal fistulas and sinuses.

2. The Frei test is a specific and valuable aid in diagnosis.

3. Sulfanilamide appears to produce definite beneficial results when used to treat the earlier manifestations of lymphogranuloma venereum. Improvement of the general condition of the patient with late manifestations of the disease, as well as reduction in the discharges from ulcers, sinuses and fistulas, has resulted following sulfanilamide therapy. Colostomy is advisable in patients with severe rectal stricture who do not do well on palliative management.

4. In the thirty-three patients with lymphogranuloma venereum herein described, 60 per cent also had syphilis; 100 per cent of the males and 17 per cent of the females had inguinal adenitis. Rectal stricture, perianal condylomata and rectal fistula were present in 53 per cent of the females, and 42 per cent had vulvar elephantiasis.

5. Public health measures designed to control the spread and treatment of lymphogranuloma venereum should be forthcoming.

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Practical Problems of a Physician With a Combined Obstetric and Pediatric Practice*

By H. A. SINCOCK, M. D.
Superior

THE combined specialty of obstetrics and pediatrics offers an ideal combination especially when one is particularly interested in diseases of children.

One of the outstanding objectives of a pediatrician is that of prevention of diseases or their residual manifestations; therefore, if the physician has within his control the guidance of the child from its inception, all other factors being equal, he ought to be in a position to gather a greater reward in this field of prevention.

By reviewing the neonatal mortality of the United States from 1933 to 1935,[1] we find prenatal and natal conditions comprise 80.6 per cent of all deaths, divided as follows:

	%
Prematurity	45.5
Injury at birth	13.4
Congenital malformation	10.7
Other prenatal and natal conditions	11.0

The rest of the 100 per cent is divided as follows:

	%
Respiratory diseases	5.2
Gastrointestinal diseases	2.3
All other specified causes	5.2
Unknown and ill-defined diseases	6.7

From the foregoing, it can readily be seen that the obstetrico-pediatrician's endeavors will lie in prevention of prematurity, injury at birth and the unidentified prenatal and natal conditions.

In dealing with the subject, having in mind the rearing of the infant into a normal and useful citizen, I would say we should divide it into three influential factors:

(1) The family influence.
(2) The influence of the mother.
(3) The influence of the child, itself.

The family influence.—The family influence has to do with hereditary factors in the case of both parents; the manner in which the parents are living and their general habits, from which we can conclude if the influence is good or bad. And here is one point I don't believe we consider seriously enough and that is the attitude the father is taking concerning the birth of the expected child. Ofttimes, I have found it very advantageous to take the father into full confidence and it is very surprising what cooperation he can give.

The influence of the mother.—The prenatal examinations are paramount, because from the first visit until the fetus is born at full term, we have to consider the welfare of two lives all the time and it goes without explanation that the health of the mother has its effect upon her offspring. A complete physical examination at the first visit should always include a Wassermann test; special examinations, such as basal metabolism and electrocardiographic tests; and fluoroscopic examination of the sinuses, antrums and chest, or only an x-ray examination of such structures, as the case demands. Further, we should try to gain the confidence of the mother so as to put at rest the general anxiety that has crept into the lives of our expectant mothers through lay magazines that childbirth carries with it a high mortality, especially in America. Childbirth is still a normal physiological process, and in the great majority of cases, if properly handled, will terminate as such.

The mother needs special instruction as to her diet, exercise, rest, the proper clothing, and garments for abdominal support. As to abdominal support, I would add that all supportive garments should be so constructed that while giving abdominal support they do not inhibit the intrauterine activities of the fetus. The proper type of shoes should be worn, for this factor has a lot to do with the many backaches and leg aches due to postural changes.

* Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

Proper care of the breasts is important. Insofar as this organ is the one we have to rely on later for the child's food and growth, particular attention should be given to it. The early massage of the nipples daily, to develop the erectile muscles therein, and the conditioning of the nipple by alcohol or oils as the case warrants, are indicated. I am certain if more attention is given to the breasts that the art of breast feeding which is rapidly becoming a lost art can have a rejuvenation. I know that since I am giving more and more instructions to mothers to start early with the care of their breasts, I am having more patients who nurse their infants, and for longer periods. After all we have never yet been able to improve artificially on mother's milk for infants.

While we are on the care of the breasts, I want to bring out a few points regarding the proper care of the breasts when they begin to function for lactation purposes. First and foremost, the mother should be instructed as to the time element. Few babies need nurse more than from five to eight minutes on either breast. Upon finishing, the nipple should be cleansed to prevent the saliva from the baby's mouth drying thereon. Nursing for longer periods than indicated above, just irritates the nipple and soon excoriates it. The result is painful, cracked nipples. The best way to treat cracked nipples is to prevent them.

I am certainly against the method of pulling night gowns from the bottom, where they have been covering unclean portions of the body, and then dragging them up over an area where the child has to depend on food for life. Arnold[2] has stated they have traced this factor to breast infection. Therefore, a garment that opens at the top is the one of choice for nursing. The let alone treatment for the drying of breasts when indicated gives better results than the applications of tight binders, massages, pumpings and whatnot, as is often suggested in our leading textbooks.

The mental state of the mother should be given more attention than we have previously given it. All of the 101 questions that mothers ask during their prenatal visits should be answered to the best of our ability and then, before the baby comes, you have her convinced that the rearing and feeding of a baby is a simple procedure and ofttimes thus prevent that vicious circle set up around the third or fourth day after the lying-in period where the child upsets the mother and the mother upsets the child and the mother loses her confidence in nursing the child and a bottle is instituted.

The administration of drugs during the prenatal period should be intelligent and for a definite purpose. Calcium, cod-liver oil, all types of hematic tonics, iodine, etc., should be given only as the case warrants and not haphazardly or universally.

It would be amiss if at this point nothing was said regarding analgesics. In my experience, I believe there is no one analgesic that is acceptable to all mothers, nor do all mothers need analgesics. One must be guided by several factors; namely, whether the patient is a primipara or a multipara, the temperament of the patient, cervical resistance, position of the child, length of labor and type of pain, for here again we are still dealing with two lives.

Before proceeding with the third influence, I would like to call attention to the data in tables 1 and 2, prepared from 150 cases taken at random from my files,[3] and data on twins which are included to show that, whether the pregnancy is single or multiple, the weight gain of the mother has no relation to the weight of the infant.

From these tables the practical points that one can assume are that the mother's gain in weight has no influence upon the size of the baby; and, that with the blood picture as here presented, the mother cannot possibly store in the body of the fetus the amount of iron necessary to carry the infant through the lactation period. Therefore, it behooves us to look for anemias in the infant after the sixth week, rather than the sixth month.

The influence of the child.—We have been told that it has been appointed unto each man but once to die. We can change this and say "It is appointed unto each child but once to pass through the birth canal," and, when we consider that 13.3 per cent of the neonatal deaths are caused from injury at birth, one

TABLE 1.—*Data on 150 Pregnancies (80 of the Mothers Were Primiparas, 70 Multiparas)*

Age of mother		Type of delivery		Weight of mother (in lbs.)		Birth weight of baby (in lbs.)		Blood findings of mother	
	Yrs.			At first visit (normal weight)	Gain during prenatal period			Hemoglobin	Red cells
Youngest	16	Normal	81	Minimum 85	Minimum 4	Minimum	5⅛	Minimum 47%	Minimum 2,080,000
Oldest	46	Instrumental	66	Maximum 200	Maximum 90	Maximum	9 13/16	Maximum 85%	Maximum 4,390,000
Average	26	Version	3	Average 133	Average 27	Average	7	Average 65%	Average 3,750,000

TABLE 2.—*Total Weight Gain of Mothers During Twin Pregnancies Contrasted With Birth Weight of Infants*

Case No.	Total weight gain of mother Lbs.	Birth weight of infants First infant (lbs.)	Second infant (lbs.)	Sex
1	19	6	7	Girl & boy
2	32	5 9/16	5½	Girls
3	17	3 7/16	4 3/16	Boys
4	31	7	5½	Girl & boy
5	90	6¼	5⅞	Girls
6	16	5½	6⅜	Girl & boy

can readily understand the hazards to which the child is subjected.

As physicians, we know how difficult it is to handle the conditions resulting from birth trauma, cerebral injuries, fractured bones, and lung ailments, not to mention congenital anomalies, and when these conditions are complicated, so much the worse. I believe the obstetrico-pediatrician is more particular in trying to determine the size of the baby he is dealing with and its position prior to delivery than most physicians.

I am always anxious to know the position and in ascertaining this I am resorting more and more to the use of the x-ray, for besides giving information as to position, this method also gives information as to the relative size of the fetus. During the last two prenatal examinations, I listen intently to the fetal heart tones and the funic souffle, because I am very anxious to know, if possible, where that placenta is placed. During labor, I am particular that the fetal heart tones be watched carefully and if the rate changes materially from what it was on entrance to the hospital, I wish to be notified and make an investigation to determine the cause of this change in fetal heart tones and the procedure necessary to rectify the same.

After the birth of the child, to be able to handle the child with the knowledge of a pediatrician, certainly has its value. It is important to provide proper resuscitation of the child by the careful aspiration of all mucus from the upper respiratory tract, and above all to see that the child is not manhandled; to supervise the heat and care of the child immediately following the birth and the proper placing of the child in the crib with elevation of the head or foot of the crib as the condition demands. After the child has overcome the effects of birth, itself, it should be given a thorough examination before twelve hours. Then the proper control of its activities as to nursing should be started.

I have a routine that I have followed for a number of years, both as to care of the infant physically and its feeding. All infants are kept in a warm room of 85 F. for at least one hour following the birth if the delivery was a normal one and the child does not show any ill effects of labor. They are oiled and then placed in their cribs, preferably on the right side. In six hours they are put to the breast. Thereafter they are fed every six hours for forty-eight hours, after which time they are switched to four-hour feeding and fed every four hours throughout the lying-in period. If the labor has been a severe, hard one, the child is not oiled for from two to four hours after birth, but is put to the breast if possible on the sixth hour and handled as the other infants. I am sure this early breast stimulation helps in the earlier production of milk. So far, I have never interested myself much in the loss of weight immediately following birth and I cannot recall a case where it has done any harm. Further, I have never been worried about whether the child has regained its birth weight when the lying-in period has finished providing the child is relishing its food and seems contented.

If the child seems hungry, I have no objection to a three-hour feeding, going back to a four-hour schedule when it seems advisable.

Any child below five pounds in weight is treated as a premature or immature infant

and is kept in the nursery or the extra heat tents, depending upon its physical condition, size and degree of prematurity. It is fed pumped breast milk by the method which meets the condition of the child whether it be with a Brecht's feeder or medicine dropper, by gavage or other method.

One point I believe is most practical and that relates to circumcision. I am convinced the best time to do this is at the time of birth. The coagulability of the blood is low immediately following the birth of the child, sutures are seldom needed and the healing is finished before the child leaves the hospital. Before doing this, however, one should have an understanding with the parents to avoid any medical–legal entanglements. I have done this for the past several years and have now performed over 400 circumcisions without mishap.[3]

I believe that one should be most observant to the newborn's condition because a big part of our diagnosis is dependent on objective findings. Points to bear in mind include the following:

The cry

(a) The cry is almost the sole means of expression.
(b) A normal cry is loud and vigorous and almost denotes a pleasurable experience.
(c) A cry of hunger or thirst is described as fretful and is usually attended with lip or hand sucking.
(d) Shrieking cry denotes pain. If it starts out slowly and reaches a marked crescendo and then fades out it denotes a pain in head or abdomen.
(e) Short, weak grunt denotes
  1. Cranial pressure
  2. Pulmonary condition
  3. Immaturity
  4. Shock
(f) Continuous cry, same volume, denotes soreness or some injury to body.

Cyanosis

Cyanosis is present in some degree in 85 per cent of all infants.

(a) When intermittent in character, it denotes intracranial damage, especially if combined with twitchings.
(b) When constant it indicates
  1. Marked atelectasis
  2. Congenital heart lesion
  3. Pulmonary obstruction infection
  4. Immaturity

Pallor

Pink-red (normal).
Grayish white, bleached, pasty (shock).

Convulsions

(a) Twitchings involving arms, legs, eyelids and intermittent in character denote intracranial pressure, concussion or edema of brain.
(b) When one side is affected, pressure on the opposite side of the body is indicated.
(c) Cyanosis and convulsions denote lesion of supratentorium.
(d) Generalized convulsions with carpal, pedal spasm indicate calcium deficiency.

Time of onset of symptoms

(a) From birth to three days
  1. Intracranial pressure
  2. Asphyxia
    (a) Atelectasis
(b) From three days to one week
  1. Same as above
  2. Pneumonia
(c) From one week to one month
  1. Some acquired disease

In conclusion, I should like to say that the obstetrico-pediatrician has every advantage in lessening the dangers of that period of greatest mortality in infancy, that is, from the first through the seventh day.

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DISCUSSION

Homer M. Carter, M. D., Madison: For many years the combined specialty of obstetrics and pediatrics has been practiced by several of us throughout Wisconsin and elsewhere. I want to thank Dr. Sincock for introducing this subject for our thought and discussion today. The subject of the paper is too inclusive for me to attempt to disagree with anything Dr. Sincock has said, but I will add one or two thoughts which have been brought out in my own practice.

First, as to the "Family influences;" here, I believe that the adjustment of the parents to each other is extremely important. In our practice we have suggested the study of such a book as "Emotional Adjustment in Marriage," by Le Mon Clark, M.D.

Next, as to the prenatal family influences, the father's instruction is very apropos.

In regard to postnatal family influences, the whole household must be educated and adjusted to the new day and night schedule.

During the last ten years, in approximately 500 patients, we have found the following interesting blood findings in about 80 per cent of the normal patients: first, the hemoglobin and red blood count are down at or just before delivery and the white count up; eight days later the reverse is true, i.e., a gradual return to normal.

The practical problems of the physician limiting his practice to obstetrics and pediatrics are: first, the same problems of prenatal, natal, and postnatal care as presented to any obstetrician; next, the same problems of infant feeding, immunization, and contagious children's diseases as presented to the pediatrician.

But the most fascinating to me are the *distinctive* problems of a combined practice of obstetrics and pediatrics, such as the adjustment of the mother and the baby more carefully and completely, not only in the hospital but in the home and at the office. At the hospital, for the past five years, we have instituted a special pre-lactation feeding program, whereby the babies seem to be happier, stronger to nurse, and return to birth weight by the fourth to sixth day, at which time they are shifted from the three-hour to the four-hour feeding.

Dr. Sincock's explanation of circumcisions done on the birth table are very interesting. We still do them toward the end of the first week.

On the third day after the mother and baby leave the hospital, we make a call at the home. We find this the most satisfactory way of adjusting the mother and baby to the home environment.

For the last year we have had a baby clinic at the office once a week for feeding consultation for the first year. For this we make a minimum charge, and many mothers prefer it to the free clinics.

With the above procedures at the hospital, home, and office we feel that we have more complete control over the immunization program, which we feel should be completed during the first year, i. e. against whooping cough, diphtheria, tetanus and smallpox.

Another distinctive problem, it seems to me, for the obstetrico-pediatrician, lies in the numerous phases of endocrinology from the viewpoint of obstetrics and pediatrics.

Early Diagnosis of Pulmonary Tuberculosis in General Practice*

By REUBEN H. STIEHM, M. D.
Madison

WITHOUT the advantage of certain methods of examination repeated at regular intervals, the individual destined to develop pulmonary tuberculosis will in most instances have it found no earlier today than years ago. Though the death rate continues to show a yearly drop, this fortunate occurrence has been due to factors other than earlier diagnosis. Tuberculosis as it affects the individual will always continue to be a very personal problem, and a falling death rate in the general population offers little solace to the individual with moderately or far advanced tuberculosis who has not had the benefit of an early diagnosis. For him the problems of treatment are multiplied, the time of cure is prolonged, and the prognosis is less favorable.

For centuries certain diseases, among them pulmonary tuberculosis, have been associated with well known symptoms and physical signs. Considering early diagnosis this association has been unfortunate, for minimal tuberculosis, and, not infrequently moderately advanced disease, occur without producing symptoms. The process has usually reached the far advanced stage before symptoms are sufficient to make the patient consult a physician. Moreover, association of pulmonary tuberculosis with symptoms and physical signs offers an adequate explanation why, according to a recent survey of the American Medical Association[1], only 13.1 per cent of 66,861 patients were admitted to sanatoriums in the minimal stage, while 29.7 and 57.2 per cent, respectively, were in the moderately and far advanced stages. Compared to the earlier studies of Drolet[2] (1926) and Whitney[3] (1931) no progress as regards earlier diagnosis has been made. Because treatment early in the disease is the biggest factor in recovery, it is unfortunate that late diagnoses are still the rule. Today, the time and efforts of sanatorium physicians are, of

* From the department of student health, University of Wisconsin. Presented at the 98th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1939.

necessity, directed in caring for the large proportion of patients who have far advanced tuberculosis—cases which emphasize the futility of treatment late in the disease.

Methods of Early Diagnosis

The diagnosis of minimal pulmonary tuberculosis is dependent on repeated examination of the apparently healthy for tuberculous infection and disease, and adequate appreciation of the fact that minimal pulmonary tuberculosis rarely produces a clinical picture of the disease. The success of dairymen in many states in reducing tuberculous infection in cattle to less than 0.5 per cent, suggests the value of a similar effort among humans. Much money and effort has and is being expended in treating the 87 per cent with moderately or far advanced disease, but comparatively little is being done to find those with the disease still in the minimal stage.

Tuberculous infection is determined by a properly administered tuberculin test. The Mantoux or intradermal test is the one of choice, though in certain cases of parental objection other methods of administration may be necessary and desirable. A good standard tuberculin should be used and a dose up to 1 mg. should be given before the individual is considered free of active infection. The two test method is advisable. The first test should consist of administering a dose of either 0.01 or 0.1 mg. of tuberculin. If the patient shows no reaction to this test, a dose of 1 mg. should be given. If the stronger 1 mg. dose of old tuberculin is not given, the fact must be appreciated that all cases of active tuberculosis will not be found. Of seventy-one cases of active tuberculosis discovered in a five year period, sixteen or 22.5 per cent failed to react to the weaker dose. The single strong dose method of 1 mg. O.T. is not advocated; but since in some case finding programs the single weak dose of 0.1 mg. alone is used, the fact should be emphasized that by this method, in our study of over 15,000 students, only 57 per cent of the infected would have been determined, and, as already stated, all of the active cases would not have been found. With the two dose method, 16.23 per cent (57 per cent of the total positive) reacted to the first strength of tuberculin, and an additional 12.24 per cent (43 per cent of total positive) reacted to the stronger dilution.

The recent work of Lumsden[4] concerning the adequacy of the tuberculin test in determining infection deserves to be considered, but until individuals with active minimal lesions[5] are found who fail to react to tuberculin, the test will continue to be of great practical value in making examination necessary only in those showing a positive reaction.

Unfortunately at the present time known tuberculous infection is not seriously enough considered. Since, among infected students at the University of Wisconsin, under observation for an average of three years, 1.6 per cent of the infected were found with already active tuberculosis on admission to the university or developed it subsequently, it is reasonable to assume that at least 10 per cent of the infected will develop active demonstrable disease during their life-time. It is necessary, therefore, that all the infected, as determined by the tuberculin test, have the advantage of roentgen ray examinations. Those negative to the tuberculin test should be retested annually.

Roentgen Ray Examinations

All infected individuals should receive at regular intervals a roentgenographic examination of their lungs. Those showing no evidence of disease should be re-examined at twelve to eighteen month intervals. Roentgen ray study of the lungs should, when possible, include a fluoroscopic examination. In trained hands (and without adequate experience this method of examination should not be attempted), the fluoroscope provides an economical and efficient means of discovering tuberculosis. Where an infiltration or suspicion of an infiltration exists, roentgenograms of the lungs should be requested. In individuals of average build, there is little difficulty in making the lesion visible. Because the patient's position is constantly being changed during the fluoroscopic examination, lesions lying well out in the peri-

phery or obscured by the upper vertebral trunks, heart or diaphragm, are brought into view. Better subsequent study by film is possible, because the examiner can request that a film be taken in the position in which it can best be seen. A small lesion may occasionally be obscured by the clavicle, or some other portion of the bony framework which on fluoroscopic study, because of frequent position change, is readily brought into view. Additional advantages lie in viewing the excursion of the ribs, diaphragm and the mediastinum in both the lateral and oblique positions. Such routine study is not economically justifiable with films.

Status of the Tuberculous Lesion

As already indicated, the minimal and subminimal tuberculous infiltrate found on the x-ray film produces no clinical picture of tuberculosis. It causes no fever, increase in pulse rate, or symptoms so commonly associated with the disease. Physical examination of the lungs usually reveals nothing pertinent. By all the usual standards of measurement, the patient is apparently healthy.

The presence of the small infiltrate visible on the roentgenogram necessitates further study. Does the shadow now more frequently found when no larger than 3 to 10 mm. in diameter, or present in the form of so-called "apical caps," represent an active or obsolete tuberculous focus? In the past reliance has been placed on serial roentgen ray films of the chest. But entire dependence on x-ray films is not without objection, for a process may be active, and yet may show no significant x-ray change for a period of years. The process is, however, potentially dangerous. Moreover, with serial films as the only measure of activity, further lung destruction is frequently allowed to occur and the prognosis is made less favorable. A lesion though small may constantly be feeding tubercle bacilli to the surrounding tissues, and therefore offers a constant and dangerous threat of progressive tuberculosis. How then may the status of the early lesion be determined?

Laboratory Methods

Fortunately, certain laboratory procedures make possible the determination of the status of the minimal and subminimal tuberculous lesions, long before the roentgenogram shows any significant change. Of especial importance is the isolation of the tubercle bacillus, for this at once proves the diagnosis and indicates that the lesion is active. The presence of tubercle bacilli in the sputum usually means far advanced tuberculosis, and the absence of bacilli in the sputum offers little assurance that a tuberculous process in the lungs is healed or even arrested. Repeated aspiration of the fasting morning gastric contents[6] with guinea pig inoculation provides, in comparison to sputum examination, a delicate and accurate gauge of the status of the lesion. The adequacy of gastric aspiration with guinea pig inoculation has not been widely appreciated, nor has sufficient use been made of this valuable method of examination. A positive test establishes the diagnosis and indicates that the lesion is active. It accurately measures the success of treatment, and helps to indicate how long treatment should be continued. It makes possible a more accurate prognosis. Furthermore, it is a measurement of infectiousness and helps the patient determine his relationship to society. In our series of fifty cases of minimal tuberculosis, the sputum was negative in all instances, the gastric contents were positive on stain in 18 per cent, and by guinea pig inoculation the results were positive in 72 per cent of the cases. As concerns prognosis, the persistence of tubercle bacilli in the gastric contents usually indicates an unfavorable course. Conversion from positive to negative indicates a more favorable prognosis, and the repeated absence of bacilli in the gastric contents is excellent assurance of continued retrogression of the lesion.

Study of the leukocytic reaction of the blood[7] at regular intervals frequently makes it possible to predict the subsequent course of the lesion. In a study of forty cases of early tuberculosis, occurring among apparently healthy students, it was found that a favorable leukocyte reaction indicated a

favorable course of the tuberculous lesion. An unfavorable or equivocal leukocyte response, however, indicated an unfavorable course in only 50 per cent of the cases. Repeated study of the leukocyte reaction becomes an important aid, especially where the reaction is favorable in determining treatment.

The erythrocyte sedimentation rate was found to be normal in 90 per cent of the active minimal cases, and apparently gives little assurance that a lesion is either benign or inactive. An increase in the rate, however, usually precedes the development of symptoms and usually indicates a progression of the process.

Summary

Minimal and moderately advanced pulmonary tuberculosis frequently occur without producing symptoms or physical signs of the disease. Early diagnosis is dependent on repeated roentgen ray examination of infected persons, as determined by the Mantoux test. Individuals negative to 1 mg. of tuberculin should be retested at yearly intervals.

The minute size of an infiltrate or its failure to show change on serial roentgenograms is no assurance that the lesion is either benign or inactive.

The status of the lesion and its probable subsequent course can frequently be determined by laboratory methods. The morning fasting contents by guinea pig inoculation is the most accurate and delicate method of determining that the infiltrate is tuberculous and active. The leukocyte reaction of the blood, as determined by repeated examination, is frequently an aid in determining the probable subsequent course of the lesion. The erythrocyte sedimentation rate is usually normal in the active minimal lesion.

The general practitioner of medicine, by means of the tuberculin test, repeated use of the roentgenogram, and examination of the gastric contents for tubercle bacilli, can find pulmonary tuberculosis in its minimal stage. The individual afflicted with tuberculosis can receive no greater advantage than an early diagnosis and the physician no greater satisfaction than having made the early diagnosis.

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PAMPHLETS ON EXAMINATION OF THE HEART AND ON BLOOD PRESSURE READINGS AVAILABLE

The American Heart Association, Inc., 50 West 50th St., New York City, announces the availability to physicians of two pamphlets, as follows:

"Standardization of Blood Pressure Readings," a four-page pamphlet containing the joint recommendations of the American Heart Association and the Cardiac Society of Great Britain and Ireland on the problem of blood pressure readings. The recommendations contained in the pamphlet have been approved by the Association of Life Insurance Medical Directors of America.

"Examination of the Heart," a twelve-page pamphlet outlining the clinical examination of the heart without the help of any instrument other than the stethoscope.

Comments on Treatment

EDITORS
A. J. Quick M. D., Marquette University, Milwaukee
and
M. H. Seevers, M. D., University of Wisconsin, Madison

Cobra Venom in Intractable Pain

Cobra venom has been utilized as an analgesic for almost ten years, particularly on the Continent. The investigations of Macht have brought the drug to the attention of practitioners in this country. Sufficient clinical data have now accumulated to warrant a summary of its actions.

Investigations indicate that the action is a neurotoxic one involving the centers responsible for pain perception, since pain of any origin may be relieved. This action on the central nervous system is rather specifically analgesic since mental processes are not dulled.

The drug is distributed in 1 cc. ampules containing 5 mouse units (Hynson, Westcott & Dunning). This dose is eminently safe when administered intramuscularly. Redness and tenderness may follow subcutaneous administration. Experience indicates that after a preliminary trial dose of 1 cc., 2 to 5 cc. may be administered daily for four to six days or until complete relief is obtained. Much larger quantities have been administered without ill effects. Following this preliminary saturation, the dose may then be lowered to establish a maintenance level which varies with the individual and may be as small as 1 cc. every third day.

The venom differs materially from other analgesics since the onset of analgesic action is delayed; three to five days may be required for full effect. Once induced, analgesia persists usually as long as three days or more after the drug is discontinued. In some instances partial relief of pain obtained after one week may be complete after three weeks. Usually, however, a trial period of ten to fourteen days is adequate to evaluate the efficiency of the drug in any given individual. Some physicians have had good success in training their patients to self-administer the drug, encouraging them to adjust their own maintenance dose after preliminary saturation during a period of hospitalization.

Very few side reactions have been encountered and there is no evidence to date of acquired tolerance to the drug or the development of addiction even after several years of administration. The cost of treatment in the average patient is not prohibitive.

Critical evaluation of the effectiveness of treatment indicates that between 40 and 50 per cent of patients with pain due to carcinoma and other allied conditions are completely relieved and 80 per cent are relieved of half or more of their pain. Results of this order have been obtained by Dr. S. M. Evans in a group of patients at the Milwaukee County Hospital. The results obtained in chronic arthritis are not very encouraging. Numerous other conditions, such as Parkinsonism, cardiac disease, arteriosclerotic gangrene, tic douloureux, have been treated but a sufficient clinical experience has not been reported to warrant a critical evaluation.

In those cases in which relief is obtained the mental outlook and general health are benefited by the absence of constant pain. It is possible often to substitute completely the venom for the opiates, or in any event greatly reduce the quantity. In less successful cases it is frequently feasible to maintain satisfactory pain relief by the use of the milder coal tar analgesics or salicylates as adjuvants to the venom therapy.

Since a few patients have refused or discontinued even successful treatment because of the knowledge that they were receiving the venom of a poisonous snake, it might be advantageous to withhold this information.
M. H. S.

THE WISCONSIN MEDICAL JOURNAL

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« « « EDITORIALS » » »

Facing the Future

NO ONE sitting through the long sessions of our House of Delegates at its Milwaukee meeting and no one attending the meetings of its reference committees where delegates and members came to discuss the merits of pending proposals, could fail to be impressed that the State Medical Society of Wisconsin is facing the future with vision.

The realistic program of the Society for 1941 is the result of many factors. It is the result of spring and summer councilor district meetings of delegates, alternates and officers to discuss the problems of medicine in Wisconsin. It is the result of Dr. Arveson's effort as president to keep delegates and county society officers constantly informed of the efforts of the Society and the problems it faces. It is the result of committees that have really functioned,—functioned in dead earnest and then provided the delegate body with their recommendations in printed and mimeographed reports well in advance of the annual meeting. This effort was then supplemented by oral, pointed reports on the floor of the House itself.

The members of the House of Delegates came to Milwaukee armed with knowledge. All its meetings were in executive session that every member of the House might speak his mind freely. Men who had served in the delegate body of the American Medical Association, characterized our 1940 sessions as exceeding in seriousness and opportunity for prior consideration any national sessions they had witnessed.

During the weeks to follow, through direct bulletins to the membership, through reports of delegates and officers to component societies, and through the columns of this Journal, all that transpired and all that was planned will be set forth in detail.

In the meantime we pay tribute to a delegate body whose membership gave up attendance upon scientific sessions that their Society, in an era of a "you are to do it this way" spirit, might in action prove that a pure democracy is the guiding light of the work of medicine.

Views of the Presidential Candidates*

President Roosevelt

THE WHITE HOUSE
Washington
September 6, 1940.

Dear Mr. Sethman:

This acknowledges your letter of August twenty-second with enclosure. The President's views on the subject about which you inquire were expressed in a speech delivered at the Jersey City Medical Center, Jersey City, New Jersey, on October 2, 1936, and, for your information, I have much pleasure in enclosing a copy of that speech. The views expressed by the President on that occasion have in no wise been changed or modified since the delivery of the speech in question and still constitute a complete statement of his principles.

(Signed) STEPHEN EARLY,
Secretary to the President.

ADDRESS OF THE PRESIDENT OCT. 2, 1936

"It is a privilege to take part in the dedication of this Medical Center—the third largest medical institutional group in the United States.

"I am happy, too, that the Federal Government through its Public Works expenditures, has been able to be of assistance to the municipal government of Jersey City and to Hudson County in making this Center possible. As a matter of fact, the expenditures through the Public Works Administration are increasing the capacity of American Hospitals by nearly 50,000 beds. During the depression the difficulty of obtaining funds through municipal or private sources would have meant a serious shortage in caring for patients and in giving them adequate facilities had it not been for Federal assistance through loans and grants.

"But there is another reason for increasing the bed capacity of the hospitals of the country. The Medical and Nursing professions are right in telling us that we must do more to help the small income families in times of sickness.

"Let me with great sincerity give the praise which is due to the Doctors of the Nation for all that they have done during the depression, often at great sacrifice, in maintaining the standards of care for the sick and in devoting themselves without reservation to the high ideals of their profession.

"The Medical profession can rest assured that the Federal Administration contemplates no action detrimental to their interests. The action taken in the field of health as shown by the provisions of the splendid Social Security Act recently enacted is clear.

"There are four provisions in the Social Security Act which deal with health; and these provisions received the support of outstanding Doctors during the hearings before Congress. The American Medical Association, the American Public Health Association and the State and Territorial Health Officers Conference came out in full support of the public health provisions. The American Child Health Association and the Child Welfare League endorsed the maternal and child health provisions.

"This in itself assures that the health plans will be carried out in a manner compatible with our traditional social and political institutions. Let me make that point very clear. All States and Territories are now cooperating with the Public Health Service. All States except one are cooperating in maternal and child health service; all States but ten in service to crippled children and all States but nine in Child Welfare.

"Public support is behind this program. But let me stress, in addition, that the Act contains every precaution for insuring the continued support and cooperation of the Medical profession.

"In the actual administration of the Social Security Act we count on the cooperation in the future, as hitherto, of the whole of the Medical profession throughout the country. The overwhelming majority of the Doctors of the Nation want medicine kept out of politics. On occasions in the past attempts have been made to put medicine into politics. Such attempts have always failed and always will fail.

"Government, State and National, will call upon the Doctors of the Nation for their advice in the days to come.

"It is many long years ago that Mayor Hague and I discovered a common interest in the cause of the crippled child. This great Medical Center is, I know, close to his heart. I congratulate him on the fulfillment of a splendid dream. I congratulate Jersey City and Hudson County on modern facilities surpassed by no other community in America."

Mr. Willkie

WENDELL L. WILLKIE
100 EAST 42ND STREET
NEW YORK CITY

Colorado Springs
August 7, 1940

My dear Doctor -

You have asked my views on socialized medicine. I am against it. You can quote me any place on this.

Cordially yours,

Dr. T. Leon Howard
Denver, Colorado.

* This material was obtained by Mr. Harvey Sethman, Editor of Rocky Mountain Medical Journal, and is here reproduced by special permission.

RALPH P. SPROULE, M. D.
President, State Medical Society of Wisconsin, 1941

Dr. Ralph P. Sproule, Milwaukee, the new president of the State Medical Society of Wisconsin, was born in Milwaukee, Wisconsin, in 1894. After a year of internship at the Milwaukee Hospital, Milwaukee, he took postgraduate work in eye, ear, nose and throat as an associate of Dr. Joseph Beck at the North Chicago Hospital from 1920 to 1922.

Dr. Sproule began the practice of his profession in Milwaukee in 1922 and has practiced there continuously since that time. He was president of the Milwaukee County Medical Society in 1930 and president of the Milwaukee Academy of Medicine in 1935. He is an otolaryngologist on the staffs of the Milwaukee and Columbia Hospitals and bronchoscopist at the Milwaukee Children's Hospital.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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Mrs. Maynard H. Fuller, Green Bay

Public Relations—
Mrs. Reuben H. Bitter, Oshkosh

National Exhibit (special committee)—
Mrs. E. Lee Lochen, Waukesha

Circulation of Bulletin (special committee)—
Mrs. Robert E. McDonald, Milwaukee

Mrs. J. S. Supernaw Named President-Elect of Auxiliary; Mrs. V. E. Holcombe, National President, Guest of Honor

AT THE twelfth annual meeting of the State Auxiliary on September 17, 18, and 19, at the Hotel Schroeder, Milwaukee, Mrs. J. S. Supernaw of Madison was named president-elect; Mrs. Samuel A. Montgomery of La Crosse, vice-president; Mrs. Harry A. Keenan of Stoughton, recording secretary; and Mrs. Edwin P. Bickler of Milwaukee, treasurer.

The meeting opened on Tuesday evening, September 17, with a dinner at the University Club for the Board of Directors which includes the state officers, together with the immediate past president, the chairmen of standing committees, and the presidents of county auxiliaries. Features of the two business sessions on Wednesday and Thursday were the addresses by the Honorable Carl F. Zeidler, mayor of the City of Milwaukee, and by Mrs. V. E. Holcombe, president of the Woman's Auxiliary to the American Medical Association. The latter address will appear in the November issue of the Wisconsin Medical Journal.

Mayor Zeidler commended the Woman's Auxiliary for its work in the field of the improvement of public health, and described the organization as a front line of defense for the ideals of American medicine. He predicted that in the coming legislative session

Mrs. Donne F. Gosin, Green Bay, President, Woman's Auxiliary, State Medical Society of Wisconsin.

many measures not in the interest of the health of Wisconsin citizenry would again be introduced, and encouraged the studying of legislative bills and the dissemination of authentic information on them. He mentioned likewise the war-torn countries of Europe and estimated that the sciences had been set back thirty-five years by these campaigns of conquest. Mayor Zeidler closed his address with the prophesy that when peace again came to the world all nations would look to America for leadership not only in medicine but in all other sciences as well.

When the new officers were installed at the business session on Thursday, Mrs. Donne F. Gosin, incoming president, was presented with the traditional president's pin. She subsequently announced her appointees for the next year as follows:

Corresponding secretary:

Mrs. Robert W. Kispert, Green Bay

Parliamentarian:

Mrs William M. Jermain, Milwaukee

Committee chairmen:

Archives—Mrs. Dana B. Dana, Kewaunee
Convention—Mrs. Arnold S. Jackson, Madison
Finance—Mrs. Robert E. Fitzgerald, Wauwatosa
Hygeia—Mrs. Gerald H. Friedman, Milwaukee
Organization—Mrs. Ernest S. Schmidt, Green Bay
Philanthropic—Mrs. Henry E. Twohig, Fond du Lac
Press and publicity—Mrs. Arnold H. Barr, Port Washington
Program—Mrs. Maynard H. Fuller, Green Bay
Public relations—Mrs. Reuben H. Bitter, Oshkosh
National Exhibit (special committee)—Mrs. E. Lee Lochen, Waukesha
Circulation of Bulletin (special committee)—Mrs. Robert E. McDonald, Milwaukee

The following Committee on Nominations was elected:

Delegates:

Mrs. Andrew S. Pfeiffer, Racine, chairman
Mrs. William H. Krehl, Madison
Mrs. Bernard W. Mast, La Crosse
Mrs. Louis V. McNamara, Montello
Mrs. Harry J. Heeb, Milwaukee

Alternate Delegates:

Mrs. Carl N. Neupert, Madison
Mrs. William C. Liefert, Milwaukee
Mrs. Carroll D. Partridge, Cudahy
Mrs. Fred J. Pfeiffer, New London
Mrs. James W. MacGregor, Portage

Social Events

To those who attended the social events at the annual meeting this account will bring back happy memories of friendly greetings, smart clothes, beautifully appointed parties, amusing stories, superior food such as frozen rum custard, suitable prizes, excellent speakers, and accomplished hostesses.

Those who could not be in Milwaukee on Wednesday missed, first, a delightful luncheon for which the Crystal Ballroom of the Schroeder Hotel was softly lighted to bring out the warm greens of rug and draperies which served as a background for the jewel-like yellow, orange and scarlet of zinnias and gladiolas. Tall vases of these bright flowers accented archways and windows. The tables, which were decorated with brilliant bouquets, were set for four for luncheon and for the bridge which followed. Mrs. V. E. Holcombe, president of the Woman's Auxiliary to the American Medical Association; Dr. R. G. Arveson, president of the State Medical Society; and the Reverend Raphael C. McCarthy, S. J., president of Marquette University, were the speakers. Table prizes consisting of sets of ash trays and many beautiful door prizes were awarded during the afternoon.

The Fiesta on Wednesday evening was gay and informal. Seated at small tables of four, six or eight, the guests enjoyed a colorful program of Mexican music and dances by costumed performers under the direction of Mrs. Lorna Warfield. Colored table cloths, centerpieces of bright vegetable arrangements, a real Mexican supper, and several members of the Milwaukee County Auxiliary in Mexican costumes completed the Latin-American atmosphere.

In contrast to Wednesday's parties were the more formal parties on Thursday. The Crystal Ballroom was lighter, the flowers were cool combinations of orchid-pink gladiolas, lavender and purple asters, and blue delphinium. The tables were larger than on Wednesday, seating eight each, and there was soft music. Mrs. Holcombe again greeted the guests and Dr. R. P. Sproule, in-

coming president of the State Medical Society, spoke briefly. Mr. Phil A. Grau, radio commentator, was the principal speaker. Following the talks there was an unusually beautiful fashion show by Stuarts.

To climax two days of solid enjoyment came the annual dinner at which formal clothes, many in pastel tints, and large corsages and shoulder bouquets were much in evidence. Dr. W. D. Stovall, director of the State Laboratory of Hygiene, was awarded the Society's gold medal for distinguished service. The treat of the entire evening was the dynamic address given by Dr. Eben J. Carey, dean of Marquette University School of Medicine.

"Be Prepared to Argue, Explain and Combat . . ."

By R. G. ARVESON, M. D.*
Frederic

Madam President, Members of the Auxiliary:

WHEN I was named President-Elect of the State Medical Society, or at least soon thereafter, Mrs. Arveson and I were visiting in the home of a doctor in Minneapolis. His wife congratulated me most cordially and said, "Well, I hope you will do better than an officer of our Society did in his talk to our auxiliary. Such grammar, it was something terrible."

The worst was out—grammar!

I have stayed awake nights thinking about it, and when she said that, a knife seemed to go through my heart. So today, having been asked by your President, Mrs. Pope, to say a few words, I think the title of my talk ought to be "My Life Is in Your Hands."

Seriously, however, I am very much interested in the Auxiliary. It is a relatively new body when you consider that the Society itself next year will celebrate its one hundredth anniversary. It is just finding itself,—learning to walk, so to speak. There is in your organization much potential strength and help that you can give to your husbands.

The Auxiliary ought to know fully all about the great struggle the profession of medicine has been going through and that it still has to pass through.

There is a great conflict of thought in the minds of men in the world today as to what form of government shall rule over collected peoples. In Europe there has been an upheaval in political thought with a marked spread of Communism—call it Fascism or Nazism or what you will. It has been stated by its exponents that it will gather the natural resources, the farms, the mines and factories, and make them the common property of the people. There is no question but that in theory the idea sounds excellent but those of us who are still able to think, know that men are greedy and the day of dividing freely with your neighbor has not arrived. Out of all this, dictators have arisen who have abolished courts and substituted the firing squad, who have farmed out babies to government care so as to allow the mothers to work for the state, and who have reduced medicine to a condition of shambles.

Here in America we have more or less imitated Europe for the past 300 years, and naturally, we have absorbed some of these strange ideas. In the past twenty-five years there has been a tremendous increase in so-called education, so much so that we have innumerable people with college degrees and yet who cannot find jobs. These people, more or less, together with a certain type of college professor who has existed comfortably in most cases with a life of security, and also together with a certain type of woman with plenty of money and time upon her hands, have been the advocates for a change, and advocates for a European system of government in spite of the fact that the defects in that system are so apparent.

The profession of medicine in this country has been subjected to unlimited pressure to make it conform to this European system. Realizing that medicine in Europe has now sunk to a new low level, naturally we have

* Address delivered September 18, 1940, by Dr. Arveson, then president of the State Medical Society of Wisconsin, to the Woman's Auxiliary of the State Society, at the annual meeting of the Auxiliary in Milwaukee.

fought to maintain our present standard here.

It would be well if you, as a state body and in your local county societies, made an attempt to become fully acquainted with this movement. It is very vital to you from an economic standpoint. And it is very vital to you that you understand fully, a rapidly changing point in the history of man, the equal of which the world has never known.

If you can forsake your contract bridge for a time, if you can forsake for a time many of the trifling things which all of us do, to study the plight of American medicine and become so familiar with it that you can intelligently discuss it with other women not allied to our profession, then you can do more good for medicine; you can, in fact, do more about it with the public than your physician husband.

I am astonished at times, in conversation with physicians, to learn how little most of them know about socialized medicine. Many of them and the public at large seem only to see the doctor paid by the state and getting medical service free of charge. The idea is ridiculous. The profession of medicine is an intimate part of society. If it is uprooted and destroyed, then one of the arch stones of society will have been destroyed.

We have learned a lot in recent times. Fortunately, Europe has supplied object lessons that we will never forget. We have seen dictators lead whole peoples, either by force or by propaganda, into new ways of thought. We have seen them destroy easily age old principles such as thrift, self-denial, self-discipline, and love of family, which took centuries to cultivate. These self-appointed dictators, by ridicule, lies, and threats, have caused innocent people to disbelieve in proved fundamental principles and seek a new existence in a land where no one will have to labor, no one will have to save for old age, all will be a Utopia when the old and proven laws of economics and social behavior are uprooted.

We know what happens when social experiments fail to produce the promised results, when unemployment and deficits continue to grow. We know what happens when the Constitution is tampered with and there is no due and just enforcement of the law. All of this philosophy is put forward by two classes of people—the first zealots and confirmed introverts with paranoid tendencies, and the other of dreamers with a Pollyanna type of mind. If you look back over the whole mess, you will see that minorities have forced their ideas upon the masses and made them stick.

Look at the plight of France. Leon Blum, a former premier, wrote a book in which he ridiculed the idea of Germany ever attacking France, that it never would violate the Covenant of the League of Nations or the Kellogg Peace Pact. He said the thing to be afraid of was not Germany, but the military-financial oligarchy within their own country. He proposed a new deal for France. Dozens of new economic and financial reforms were enacted, and yet all of them struck at the very roots of the nation's long established social pattern. Seventy new laws were enacted in the first two months, a forty-hour week, collective bargaining, annual paid vacations. In fact, they did everything we have been doing here. Excessive government spending brought inflation. The ranks of French labor soared 400 per cent. There were sit-down strikes.

Daladier took hold and tried to bring the French people back in eighteen months to a realization of a sense of proportion, and you know what happened to France when Germany struck her. She fell; proud France, that had endured for centuries, fell because a minority had inflicted upon an unorganized majority some hare-brained ideas of how to live without labor and sacrifice.

France was a great country. So is our country a great country, but if the old world philosophy takes root here unhampered, *"it can happen here."* Remember this, in Europe medicine was one of the first things to be socialized. After this started the deluge, and even out of Pandora's box there never came so many bizarre ideas.

Therefore, I am asking you to study and acquaint yourselves with the history of this movement and to be prepared to argue, explain, and combat it among your friends.

You have a wonderful opportunity, a great mission, MAKE THE MOST OF IT!

Address of 1940-1941 Auxiliary President

By MRS. DONNE F. GOSIN
Green Bay

Madam Chairman, Members of the Auxiliary:

I FEEL it a great privilege and honor to be asked to serve you, and it is with deep humility that I approach my task.

When I look at the qualifications of my predecessors, their poise, their calm, their wise judgment, their charm and graciousness, I am truly awed. And in reading the message of Mrs. Rollo K. Packard (president, Woman's Auxiliary to the American Medical Association) to the National Bulletin for June, 1940, in which she lists the qualifications essential to officers and leaders, I am less assured of my capacity. May I quote these, for I found in this list and in the reports of various committees much food for thought, and the keynote of my message to you:

1. Knowledge of the organization.
2. Knowledge of county, state, and national by-laws.
3. Knowledge of the functions of the various committee chairmen.
4. Willingness and determination to work.
5. Time to devote to the work.
6. A broad general knowledge of the various problems confronting the medical profession today, and attempts or plans to settle their problems.
7. Knowledge of the organization, administration, and functions of the American Medical Association and its various committees and bureaus.
8. Knowledge of medical education and its progress—particularly in the last thirty years.
9. Knowledge of some of the major accomplishments of American medicine.
10. Knowledge of hospital standards; also of hospital facilities and hospital needs in the United States.
11. And last, the ability to present these facts—first to the members of our own organization, and secondly to the lay groups we contact.

These are perilous times for the members of the profession. The practice of medicine is being stripped of its dignity and is being unjustly criticized and accused of unfair practices. Our hospitals, the finest in the world, are being assailed. We, the helpers, are members of every lay organization in our local communities. We have a wonderful opportunity to disseminate quietly and efficiently, the proper information to every one of these groups. However, we must be carefully informed, for I maintain that no one can present an idea with enthusiasm and authority without a definite knowledge of his subject.

Where do we find the authentic information we desire? From our national and state medical journals and our own official Bulletin. Mr. Crownhart, secretary of our State Medical Society of Wisconsin, is also most willing and anxious to answer questions and send us material.

So I would urge first, that every member of the Auxiliary acquaint herself, as Mrs. Packard suggests, with a broad knowledge of her own organization. Know the personnel of the national group (we are honored here in Wisconsin with three members of the National Board). Know the national and state constitution. Know the state organization and personnel. Read reports of national and state chairmen. Read the Journal of the American Medical Association and the Wisconsin Medical Journal regularly. Train your husbands to bring these home to you. Do this as a bit of leisure reading for the years 1940 and 1941. It is tremendously interesting and inspiring. And I would go further and ask each county president to devote a few minutes of every meeting to current events culled from these sources.

We are too casual, too complacent—and yes, even smug. Our power to mould public opinion to our way of thinking is unlimited. It must be the responsibility of each auxiliary member to be informed and to do her bit.

We, as doctor's wives, should be proud of our organization—proud to be recognized as members of this great Auxiliary and willing

to give of our time and our energy to further its aims.

As I look back through my years of service, eleven with the Minneapolis group and seven with the Brown–Kewaunee–Door Society, my heart warms to the memories of the happy contacts I have made. I am looking forward to added pleasant associations with you. But I bid you be most patient, generous, and kind in your judgment of my efforts. I ask your help, your interest, and your cooperation.

Report of the 1939-1940 Auxiliary President

By MRS. FRANK W. POPE
Racine

IN TAKING over the office of president of the Woman's Auxiliary to the State Medical Society of Wisconsin, it was my desire to increase membership and activities in all departments, especially public relations meetings, secure first place in the national Hygeia contest, and visit as many counties as possible.

I have endeavored to follow closely the object of our organization as set forth in Article 2 of our Constitution.

> "1. To extend the aims of the medical profession to all organizations which are interested in the improvement of public health and the advancement of health education.
> "2. To encourage kindly social relationships and to promote mutual understanding among physicians' families.
> "3. To cooperate with the State Medical Society of Wisconsin in the promotion of public health and social welfare.
> "4. To initiate or to assist in work that is approved by the State Medical Society of Wisconsin.
> "5. To assist in the entertainment at all conventions of the State Medical Society of Wisconsin."

It was an extremely cold day in January when our board meeting was held, but despite bad weather thirty-one members were present, some of them coming from great distances. Plans for the year were presented by chairmen of various committees, and when the meeting was over we felt that the work was well planned for the coming year. Whatever has been accomplished this year has been through the efforts of our hardworking and determined coworkers plus the cooperation of all the members. It is the work of the committees in their several departments that I wish to elaborate on in this report.

On September 1, our membership was 1,212, a slight increase over last year. There were twenty-seven units representing thirty-seven counties. With the loss of one county and the gain of another, our units remained the same as the previous year. The disbanding of the Grant County Auxiliary gave us great concern, as we cannot afford to lose any county that has once been active in Auxiliary work. Although our efforts to keep the Grant County Auxiliary with us failed, it is hoped that in the near future it will again join our ranks. To Sauk County, our newest auxiliary, we extend a hearty welcome. These new members have come to us with enthusiasm, and it is to be hoped that they will avail themselves of the many pleasant duties and advantages of the State Auxiliary. Organization is slow work, but Mrs. Ernest S. Schmidt, Green Bay, has been a persistent chairman, and it was through her efforts that the new unit came to us.

For several years it has been the wish of the Auxiliary to win the Hygeia contest, and Mrs. Irenaeus N. Tucker, Racine, was most determined to do it this year. She used every possible method to obtain subscriptions and while the goal was not reached, about 900 subscriptions is a splendid record. This put us in fourth place, of which we can still be proud.

Two of this year's chairmen worked hand-in-hand, Mrs. James C. Hassall, Oconomowoc, and Mrs. Ira F. Thompson, Racine, who headed the program and public relations work respectively. After careful considera-

tion of the national program, Mrs. Hassall and Mrs. Thompson presented their state programs to the Advisory Board. It took real effort to make such a splendid showing in public relations meetings, and if you have read the Auxiliary news, you know that several large ones were held. This year there were many speakers available, men well qualified to speak, men willing to give their time,—and we were happy to take advantage of this excellent opportunity.

Mrs. Arnold S. Jackson, chairman of press and publicity, was particularly active, and with generous space given us in the Wisconsin Medical Journal there was a great deal of interesting news of comings and goings of Auxiliary members. Mrs. Jackson set out to get all the news and she succeeded.

Mrs. Cornelius A. Harper, Madison, with archives her chief interest, worked diligently on the task assigned her by Mrs. John J. Ryan, national archives chairman. The Wisconsin Auxiliary will now have its place in the National Book of Archives, and the work of Mrs. Harper will serve us well in future years.

Making many friends for the Auxiliary by her originality and thoughtfulness Mrs. Edgar F. Andre, Kenosha, did her share as chairman of philanthropic work.

The national exhibit, which you may see at this convention, has come from the work of Mrs. E. Lee Lochen, Waukesha. Do take the time to look at it for it is an interesting record of our county organizations. A summary to date of information obtained from records of 1838 to 1939—a period of 101 years—has been prepared and represents many hours of work on the part of Mrs. Joseph B. Noble of Waukesha.

Mrs. William E. Buckley, Racine, was glad to be of service on the Nominating Committee, taking the chairmanship for Mrs. Oscar W. Friske, Beloit, whose illness prevented her from finishing the work.

To the chairman of finance, Mrs. Arthur J. McCarey, Green Bay, who cannot be with us today because of illness, we are thankful. Her problem was to make both ends meet as far as finances are concerned.

My travels in visiting the following nine county auxiliaries have been a pleasure: Brown–Kewaunee–Door, La Crosse, Milwaukee, Sheboygan, Waupaca–Shawano, Fond du Lac, Rock, Kenosha and Waukesha. In November I attended the National Board meeting in Chicago, and in June, the National Convention in New York City held my attention. These meetings were an inspiration, giving me the opportunity to see first-hand the immense amount of work done by national officers.

Wisconsin can well be proud of its work in the national organization as many of our members have held important positions on the National Board. At present Mrs. Robert E. Fitzgerald, Wauwatosa, is chairman of revisions, Mrs. Eben J. Carey, Wauwatosa, is a two-year member of the Board of Directors, and Mrs. George H. Ewell, Madison, is chairman of press and publicity. These honors have come to them for showing exceptional interest and ability.

Throughout the year requests have come for four reports and seven articles for publication in the National Bulletin and Wisconsin Medical Journal. These requests as well as the writing of hundreds of letters necessary to take care of Auxiliary business were taken care of as soon as possible. It was pleasant to receive so many letters from all over the state, and I shall miss these friendly messages more than I can tell you. For whatever work I have done, I have been more than repaid in new friendships and pleasant memories.

All worries about the state convention have been cast aside, knowing full well that Mrs. Eben J. Carey, chairman, and her able committee, would do all in their power to make your stay here delightful. A knowledge that Mr. J. G. Crownhart, secretary to the State Medical Society, and Miss Lucia Stolp, his personal secretary, have stood ready all through the year to help and advise, has been a comfort. County presidents have shown such interest in our projects that correspondence with them has been most gratifying.

I am not unmindful of the honor you have given me. Serving as your president for the past year has been a joy and a privilege and while the goal has not been reached, a gen-

eral plan was followed of establishing friendly relations and keeping and upholding the traditions that form such an important part of medical life. There is turmoil in the world. We need organizations that cherish and work toward high ideals. May our Auxiliary in the State of Wisconsin be one of these and may the day come when we as individuals may feel that our efforts have helped to restore peace and happiness to the world.

And so ends a pleasant chapter in my life in which each one of you has taken part. My good wishes go with the Auxiliary, and I shall cherish recollections of happy associations in the years of 1939–1940.

Registrants at Auxiliary Meeting

Brown–Kewaunee–Door

Dana, Mrs. D. B.
Duvall, Mrs. Clarence (guest)
Fuller, Mrs. M. H.
Gosin, Mrs. D. F.
Knox, Mrs. E. S.
McNevins, Mrs. E. S.
Nadeau, Mrs. E. G.
Quigley, Mrs. L. D.
Wochos, Mrs. F. J.

Columbia–Marquette–Adams

Caldwell, Mrs. H. M.
Gillette, Mrs. H. E.
McNamara, Mrs. L. V.
O'Connell, Mrs. Ernest (guest)
Pease, Mrs. W. A.
Tierney, Mrs. E. F.

Dane

Brindley, Mrs. B. I.
Bryan, Mrs. A. W.
Crownhart, Mrs. J. G.
Ewell, Mrs. G. H.
Ganser, Mrs. W. J.
Greene, Mrs. H. L
Harper, Mrs. C. A.
Hill, Mrs. N. A.
Holmgren, Mrs. L. E.
Hurlbut, Mrs. J. A.
Jackson, Mrs. A. S.
Keenan, Mrs. H. A.
Krehl, Mrs. W. H.
Larson, Mrs. G. B.
Littig, Mrs. L. V.
McCormick, Mrs. S. A.
Reznichek, Mrs. C. G.
Sprague, Mrs. L. V.
Stebbins, Mrs. G. G.
Sullivan, Mrs. W. E.
Supernaw, Mrs. J. S.
Werrell, Mrs. W. A.

Dodge

Costello, Mrs. W. H.

Douglas

Doyle, Mrs. T. J.

Dunn (no Auxiliary organized)

Steves, Mrs. R. J.

Fond du Lac

Connell, Mrs. J. P.
Dalrymple, Mrs. R. R.
Devine, Mrs. J. C.
Finn, Mrs. W. C.
Gavin, Mrs. S. E.
Guenther, Mrs. O. F.
Hoffmann, Mrs. L. A.
Hutter, Mrs. A. M.
Johnson, Mrs. J. M.
Keenan, Mrs. L. J.
Nehmer, Mrs. Paul
Pawsat, Mrs. E. H.
Raymond, Mrs. R. G.
Theisen, Mrs. S. A.
Yockey, Mrs. J. C.

Green Lake–Waushara

Seward, Mrs. L. J.
Sinaiko, Mrs. E. S.

Kenosha

Andre, Mrs. E. F.
Bennett, Mrs. W. H.
Hirsh, Mrs. Sidney
Kleinpell, Mrs. W. C.
Lokvam, Mrs. L. H.
Pechous, Mrs. C. E.
Rauch, Mrs. A. M.
Ripley, Mrs. H. M.
Robinson, Mrs. Flora H.
Schlapik, Mrs. A.
Schulte, Mrs. G. C.
Schwartz, Mrs. H. L.
Sokow, Mrs. T. H.
Stewart, Mrs. W. C.

La Crosse

Gundersen, Mrs. Gunnar
Montgomery, Mrs. S. A.

Manitowoc

Donohue, Miss Helen
Donohue, Mrs. W. E.
Moriarty, Mrs. L. J.
Rees, Mrs. T. H.
Teitgen, Mrs. T. A.

Marinette–Florence

May, Mrs. J. V.

Milwaukee

Ackerman, Mrs. J. S.
Adamkiewicz, Mrs. J. J.
Bardenwerper, Mrs. H.E.
Barta, Mrs. E. F.
Baumann, Mrs. A. J.
Behnke, Mrs. E. J.
Bender, Mrs. B. I.
Bickler, Mrs. E. P.
Bergen, Mrs. R. D.
Blumenthal, Mrs. R. W.
Bork, Mrs. A. L.
Bornstein, Mrs. S. L.
Bourne, Mrs. N. W.
Broderick, Mrs. C. F.
Brunkhorst, Mrs. R. O.
Brussock, Mrs. W. A.
Brzezinski, Mrs. E. A.
Budny, Mrs. C. L.
Bussewitz, Mrs. M. A.
Cannon, Mrs. H. J.
Carey, Mrs. E. J.
Casey, Mrs. F. (guest)
Champney, Mrs. R. D.
Churchill, Mrs. B. P.
Clark, Mrs. G. F. (guest)
Cook, Mrs. H. E.
Couch, Mrs. T. T.
Cowles, Mrs. H. L. (guest)
Cunningham, Mrs. H. A.
Currer, Mrs. P. M.
Curtin, Mrs. J. G.
Davidoff, Mrs. I. Z.
Deysach, Mrs. L. J.
Dempsey, Mrs. G. P.
Doolittle, Miss Helen (guest)
Dundon, Mrs. J. R.
Elconin, Mrs. D. V.
Enzer, Mrs. Norbert
Everts, Mrs. E. L.
Farrell, Mrs. H. J.
Feldt, Mrs. R. H.
Fetherston, Mrs. J. P.
Fidler, Mrs. Charles
Fitzgerald, Mrs. R. E.
Fitzgerald, Mrs. G. F.
Foley, Mrs. L. J.
Ford, Mrs. W. B.
Frawley, Mrs. D. D.
Frederick, Mrs. R. H.
French, Mrs. H. S. (guest)
Friedman, Mrs. G. H.
Froelich, Mrs. J. A.
Fromm, Mrs. A. H.
Gabor, Mrs. M. E.
Garens, Mrs. R. W.
Gebhard, Mrs. U. E.
Gilchrist, Mrs. R. T.
Gingrass, Mrs. R. P.
Goodman, Mrs. P. P.
Gramling, Mrs. Elmer (guest)
Gramling, Mrs. Henry
Gramling, Mrs. J. J., Jr.
Griffith, Mrs. J. C.
Grob, Mrs. A. R. F.
Grotjan, Mrs. W. F.
Gumerman, Mrs. J. G.
Haberland, Mrs. J. E.
Hake, Mrs. C. B.
Hansher, Mrs. E.
Hardgrove, Mrs. M.
Heeb, Mrs. H. J.
Heidner, Mrs. F. C.
Heifetz, Mrs. C. E.
Heil, Mrs. J. V.
Heinan, Mrs. F. C.
Hermann, Mrs. A. H.
Hildebrand, Mrs. G. J.
Hiller, Mrs. R. I.
Hirsh, Mrs. L. H.
Hoffman, Mrs. G. H.
Hogue, Mrs. G. I.
Hopkinson, Mrs. Daniel
Hornierook, Mrs. James (guest)
Howard, Mrs. M. Q.
Huston, Mrs. Donald (guest)
Huston, Mrs. John
Jackson, Mrs. Edward
Jaekels, Mrs. Raymond
Janney, Mrs. F. R.
Hermain, Mrs. W. M.
Joseph, Mrs. W. A.
King, Mrs. J. M.
Klein, Mrs. J. T.
Kozina, Mrs. F. J.
Kretlow, Mrs. F. A.
Krohm, Mrs. George (guest)
Kult, Mrs. A. S.
Lang, Mrs. V. F.
Lawler, Mrs. E. M.
Lee, Mrs. P. A.
Lettenberger, Mrs. Joseph
Lieberman, Mrs. Benjamin
Liefert, Mrs. W. C.
Mackoy, Mrs. F. W.
Markson, Mrs. S. M.
Marquardt, Mrs. C. R.
Massopust, Mrs. L. C.
Megna, Mrs. Salvatore
Margoles, Mrs. M.
Massino, Mrs. J. (guest)
McCabe, Mrs. John
McCormack, Mrs. M. T.
McDonald, Mrs. R. E.
McGovern, Mrs. J. J.
McKillip, Mrs. W. J.
Mendelson, Mrs. Frederick (guest)
Meyers, Mrs. Arthur (guest)
Miller, Mrs. H. L.

Morter, Mrs. C. W.
Northey, Mrs. T. M.
O'Malley, Mrs. W. P.
Ozonoff, Mrs. J. B.
Osgood, Mrs. C. W.
Partridge, Mrs. C. D.
Peterson, Mrs. E. F.
Peyton, Mrs. L. T.
Pink, Mrs. J. J.
Powers, Miss Dorothy Ann
Powers, Mrs. H. W.
Pugh, Mrs. G. J.
Purtell, Mrs. P. J.
Rank, Mrs. R. T.
Reinke, Mrs. C. C.
Rettig, Mrs. E. T.
Rettig, Mrs. Henry
Reuter, Mrs. M. J.
Reuter, Mrs. R. J. (guest)
Rice, Mrs. E. M.
Rolfs, Mrs. T. H.
Ruppenthal, Mrs. A. J.
Ryan, Mrs. W. A.
Sargent, Mrs. J. C.
Schelble, Mrs. E. J.
Schlueter, Mrs. U. A.
Schoenkerman, Mrs. B. B. (guest)
Schowalter, Mrs. R. P.
Schubert, Mrs. F. J.
Scollard, Mrs. W. J.
Scott, Mrs. R. H. (guest)
Seegers, Mrs. F. W.
Seelman, Mrs. J. J.
Shaiken, Mrs. Joseph (guest)
Siekert, Mrs. H. P.
Silbar, Mrs. S. J.
Sleyster, Mrs. Rock
Sproule, Mrs. R. P.
Stamm, Mrs. L. P.
Stockinger, Mrs. R. E.
Sullivan, Mrs. J. M.
Sure, Mrs. J. H.
Swinle, Mrs. P. F.
Tharinger, Mrs. E. L.
Thill, Mrs. G. E.
Tobleske, Mrs. (guest)
Toepfer, Mrs. R. A. (guest)
Tufts, Mrs. M.
Walton, Mrs. W. B.
Warfield, Mrs. L. M. (guest)
Washburn, Mrs. R. G.
Witte, Mrs. D. H.
Ziegler, Mrs. L. H.
Zurheide, Mrs. H. O.

Monroe (no Auxiliary organized)

Schindler, Mrs. J. A. (guest)

Oneida (no Auxiliary organized)

Bump, Mrs. W. S. (guest)

Ontagamie

Archer, Mrs. W. E.
Bolton, Mrs. E. L.
Dehne, Mrs. W. O.
Laird, Mrs. J. J.
Landis, Mrs. R. V.
Neidhold, Mrs. C. D.
Rector, Mrs. A. E.
Towne, Mrs. W. H.

Polk

Arveson, Mrs. R. G.
Simenstad, Mrs. L. O.

Portage

Benn, Mrs. H. P.
Miller, Mrs. S. R.

Racine

Adamski, Mrs. A. W.
Browne, Mrs. C. F.
Constantine, Mrs. C. E.
Docter, Mrs. J. C.
Gillett, Mrs. G. N.
Hanson, Mrs. W. C.
Henken, Mrs. J. F.
Jamieson, Mrs. R. D.
Keland, Mrs. H. B.
Marek, Mrs. F. B.
Pfeiffer, Mrs. A. S.
Pope, Mrs. F. W.
Ross, Mrs. G. L.
Schacht, Mrs. E. W.
Schneller, Mrs. E. J.
Thompson, Mrs. I. F.
Wagner, Mrs. N. B.
Walter, Mrs. G. W.

Rock

Friske, Mrs. O. W.
Kasten, Mrs. H. E.
Kishpaugh, Mrs. H. W. (guest)

Sauk

Edwards, Mrs. A. C.
Huth, Mrs. M. F.
Moon, Mrs. J. F.

Sheboygan

Brickbauer, Mrs. A. J.
Hansen, Mrs. H. J.
Hougen, Mrs. E. T.
Mason, Mrs. P. B.

Trempealeau–Jackson–Buffalo

Bachhuber, Mrs. M. O.

Walworth

Donath, Mrs. L. H.
O'Leary, Mrs. T. J.
Rowlins, Mrs. J. A. (guest)
Sorenson, Mrs. E. D.
Young, Mrs. J. H.

Washington–Ozaukee

Barr, Mrs. A. H.
Fisher, Mrs. R. S.
Heidner, Mrs. A. H.
Hurth, Mrs. O. H.
Monroe, Mrs. M. E.

Waukesha

Aplin, Mrs. F. W.
Barnes, Mrs. H. T.
Clark, Mrs. O. C.
Coon, Mrs. H. M.
Davies, Mrs. R. E.
Davis, Mrs. A. (guest)
Edmondson, Mrs. C. C.
Egloff, Mrs. L. W.
Eisele, Mrs. P. L.
Frick, Mrs. J. C.
Gantz, Mrs. H. A.
Grover, Mrs. F. L.
Hassall, Mrs. J. C.
Heideman, Mrs. (guest)
Johnson, Mrs. H. W.
Koepp, Mrs. A. (guest)
Lochen, Mrs. E. L.
Loughnan, Mrs. A. J.
Nixon, Mrs. H. G. B.
Noble, Mrs. J. B.
Oatway, Mrs. W. H.
Peters, Mrs. H. A.
Pierce, Mrs. D. F. (guest)
Sydow, Mrs. H. F.
Wilkinson, Mrs. D. C.
Wilkinson, Mrs. J. F.
Wood, Mrs. C. A.
Woodhead, Mrs. F. J.
Zickerick, Mrs. Francis (guest)

Waupaca–Shawano

Cantwell, Mrs. A. A.
Irvine, Mrs. R. K.
Irvine, Mrs. W. J.
Miller, Mrs. E. A.
Patterson, Mrs. L. G.
Weller, Mrs. E. A.

Winnebago

Canavan, Mrs. J. P.
Connell, Mrs. F. G.
Feasler, Mrs. C. H.
Forkin, Mrs. G. E.
Koehler, Mrs. A. G.
Smith, Mrs. T. D.
Wagner, Mrs. W. A.

Wood

Bennett, Mrs. L. J.
Garrison, Mrs. R. E.
Pomainville, Mrs. H. G.

Out-of-State

Holcombe, Mrs. V. E., Charleston, W. V.
Simenstad, Mrs. M. O., Fargo, N. D.
Von der Weyer, Mrs. W. H., St. Paul, Minn.

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To County Auxiliary Presidents:

Is your chairman of press and publicity sending news of your activities to the state chairman of press and publicity?

We want to know about your programs, your projects, and your social events.

We appreciate your cooperation.

Society Proceedings

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society met on September 12 at the Beaumont Hotel, Green Bay. A business meeting was held for the consideration of the society's position on problems coming before the House of Delegates of the State Medical Society at the annual session in Milwaukee.

Dr. Ralph Sproule, Milwaukee, president of the State Medical Society, discussed problems of the Society. A talking motion picture, "Gonadogen," was shown by Mr. Edward Wolfe, representative of the Upjohn Company.

Thirty-two physicians attended the meeting.

Crawford

The Crawford County Medical Society met in September at the Savory Cafe in Prairie du Chien. Arrangements were made with the county nurse for fall health work among school children.

Fond du Lac

The Fond du Lac County Medical Society met on September 23 to hear an address on "Hemorrhagic Diseases" by Dr. Ovid O. Meyer, University of Wisconsin Medical School, Madison. Dinner was served to the group at the Hotel Retlaw and Dr. D. J. Twohig, Fond du Lac, gave a report on the recent sessions of the House of Delegates of the State Society in Milwaukee.

Rock

The Rock County Medical Society met at the Hotel Hilton, Beloit, September 24. Dinner was served, after which Dr. T. L. Squier, associate clinical professor of medicine, Marquette University School of Medicine, addressed the group on "Allergy—General Considerations in Diagnosis and Treatment."

Racine

The Racine County Medical Society on September 3 held its annual pre-convention business meeting to discuss subjects coming before the State Medical Society at its annual meeting in Milwaukee. The business meeting was held at the Elk's Club in Racine.

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met on August 22 in the Village Hall at Blair. Twelve members and three guests heard Dr. R. S. Baldwin, Marshfield, discuss "Management of Diabetes," and Dr. Stephan Epstein, Marshfield, talk on "Treatment of Common Skin Diseases."

Tri-County Meeting

A meeting of Walworth, Kenosha and Racine county medical societies, with their woman's auxiliaries, was sponsored Wednesday, September 11, by the Walworth County Medical Society and its auxiliary. The meeting was held at the Big Foot Country Club on Lake Geneva.

At the evening session, Dr. W. W. Bauer of the American Medical Association, warned against the present trend of placing health matters in the hands of politicians. Mr. J. G. Crownhart, Madison, secretary of the State Society, spoke on "The Doctor in Wisconsin and Mobilization;" and Dr. Ralph P. Sproule, Milwaukee, president of the State Society, discussed "Hospital Insurance."

A buffet luncheon followed the morning session and, in the interim before the evening session, many of the physicians played golf. A bridge party was held for members of the auxiliary.

Winnebago

The Winnebago County Medical Society met in the staff room of the Mercy Hospital, Oshkosh, September 5, at 8 p. m. Lt. H. A. Romberg, M. D., Oshkosh, spoke to the members on "My Recent Experiences in Military Service at Camp with the Medical Reserve and National Guard," and Capt. R. H. Bitter, M. D., Oshkosh, talked on "Military Medical Services and Salaries Paid to Various Officers." The secretary of the society reports "a good attendance."

Wood

The Wood County Medical Society met in Wisconsin Rapids on August 29. The following were elected to membership in the society: Drs. James S. Vedder, Thomas E. Wyatt and J. R. Talbot—all of Marshfield. Two lectures were presented on the scientific program, one by Dr. Thomas E. Wyatt on "Treatment of Burns," and another by Dr. Otto Kauder, Marshfield, on "Head Injuries; a Study of 100 Cases at St. Joseph's Hospital, Marshfield." Fourteen attended the meeting.

West Allis Medical Society

At the annual meeting of the West Allis Medical Society, September 11, at the home of Dr. Thomas Willett, the following officers were elected:

President—Dr. Marshall Stamm

Vice-president—Dr. Roland Frederick

Secretary-Treasurer—Dr. Leon Hirsh

News Items and Personals

Twenty-one of the thirty-four living members of the class of 1915, Marquette School of Medicine, met for a reunion on September 19 at the Schroeder Hotel. The class, composed largely of Wisconsin practitioners, has held a reunion every five years since graduation. Among the attendants at this year's reunion were: Drs. *C. H. Andrew*, Platteville; *E. W. Bowen*, Watertown; *W. E. Buckley*, Racine; *Q. H. Danforth*, Oshkosh; *R. L. Eagan*, La Crosse; *G. J. Juckem*, Sheboygan; *J. H. Terlinden*, Bonduel; *W. J. Frawley*, Appleton; and *J. W. Hansen*, *S. R. Mitchell*, *U. Senn*, *E. Tharinger* and *G. E. Whalen*, all of Milwaukee.

—△—

The *State Board of Health* urges physicians in the state to report cases of poliomyelitis to the Board as soon as possible, for purposes of record and for reference to the Crippled Children's Division for follow-up work. Up to September 28, the Board states 267 cases of poliomyelitis had been reported, 225 being paralytic in type. This indicates more than the average prevalence of the disease, the 1938 incidence, for instance, being 115 cases. The Board has a booklet on the after-treatment of poliomyelitis obtainable on application by any physician in the state.

The National Foundation for Infantile Paralysis has organized county chapters at various points in Wisconsin, through which braces, Bradford frames, etc., may be procured on a loan basis on request of physicians. The Board can furnish information as to the location of these chapters.

—△—

The new *Marinette General Hospital* opened its doors officially to receive patients on September 3. *Dr. A. T. Nadeau*, Marinette, will serve as president of the staff.

The new hospital now has sixty beds, but it has a bed-capacity of over eighty-four. It was erected at a total cost of $315,000. Of this $132,523 was from the federal government in the form of a PWA grant, $138,000 was from the county of Marinette, $45,000 from the city of Marinette and its citizens.

In the visiting days preceding the formal opening of the hospital, the incubator used by Dr. Dafoe to save the Dionne quintuplets was displayed.

One of the many modern features of the new hospital's equipment is a new type of basket and bassinet in the nursery made of transparent plastic and chrome stainless steel, designed by *Dr. J. W. Boren*, Marinette.

—△—

Dr. M. G. Peterman, Milwaukee, spoke on epilepsy at the annual meeting of the Utah State Medical Association in Ogden, the latter part of August.

—△—

Mr. Robert E. Oehler has been named general manager of the Milwaukee Optical Manufacturing Company to replace the late Mr. Charles Tribe. Mr. Oehler has been associated with the company for 30 years.

—△—

Beginning the first part of September, Dr. Robert Brown, physician and surgeon, and Dr. Donald Brown, dentist, will be associated in practice with *Drs. B. I. Pippin*, *R. E. Housner* and *George Parke, Jr.*, at the Pippin Clinic, Richland Center.

Examinations for appointments as commissioned officers, U. S. Navy, to be held; Information available on appointments as medical officers of the Navy.—The Surgeon General of the Navy, Rear Admiral Ross T. McIntire, (MC), U.S.N., announced September 5 that the Medical Corps of the Navy is being increased in strength proportionate with the expanding Navy and the Marine Corps. Examinations for appointments as commissioned officers in the Medical Department of the Navy will be held January 6 to 9, 1941.

Rear Admiral McIntire also announced that appointments are being made in the Medical Corps, United States Naval Reserve, of male citizens of the United States, graduates of class "A" medical schools, who are under 50 years of age and who meet the physical and professional requirements.

The examination to be held in January will be for appointment as Assistant Surgeon, in the Medical Corps of the regular Navy, effective approximately two months from date of examination, and for Acting Assistant Surgeon (Intern), effective July 1, 1941. Requests for authorization to appear for these examinations should be submitted to the Bureau of Medicine & Surgery, Navy Department, Washington, D. C., in sufficient time to permit the authorization to reach the applicant prior to December 30, 1940.

Applicants for appointments as Assistant Surgeon must be citizens of the United States between the ages of 21 and 31, graduates of Class "A" medical schools and have completed one year of intern training in a hospital accredited for intern training by the Council on Medical Education and Hospitals of the American Medical Association.

A circular of information for applicants for appointment as medical officers of the Navy, containing full information regarding physical requirements, professional examinations, rates of pay, and promotion and retirement data may be obtained by addressing the Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

Applicants for appointment in the Medical Corps of the United States Naval Reserve should be addressed to the Commandant of the Ninth Naval District, Great Lakes, Illinois, who will upon request furnish complete information regarding vacancies in ranks, etc., of officers of the Medical Corps, United States Naval Reserve in the district.

Coming Events

Clinics of Marquette School of Medicine.—Clinics will be held at the Milwaukee County Hospital beginning October 18. They will be held weekly from 10:30 a.m. to 12 noon on Friday instead of on Wednesday as formerly. (This change was made to cooperate with the program committees of the State Medical Society and the Medical Society of Milwaukee county.) Subjects for discussion in October and November are as follows:

October 18:
- Diagnosis and treatment of common gastric complaints.
- Treatment of the ruptured appendix.

October 25:
- Differential diagnosis of swelling of the neck.
- Treatment of deep infections of the neck.

November 1:
- Acute pulmonary emergencies.
- Management of chest injuries.

November 8:
- Subacute bacterial endocarditis. (Dr. W. S. Middleton, dean of the University of Wisconsin Medical School, will speak.)
- Treatment of varicose veins and ulcers.

Clinics of University of Wisconsin Medical School.—Clinics will be held by departments of the Medical School each Saturday morning from 11 a.m. to 12:30 p.m., in the main lecture room of the Service Memorial Institute, until May 25, 1941.

Throughout the year physicians are welcome to attend ward rounds, operating clinics, conferences and seminars.

Staff meetings are held bi-weekly through the academic year and the profession is welcome to attend. The programs of the next two meetings are as follows:

October 15:
- Case report on ductus arteriosus
  Drs. F. Pohle and Joseph W. Gale
- Pharmacology of sulfocyanate
  Dr. M. H. Seevers
- Treatment of hypertension
  Drs. Chester Kurtz and Herman Shapiro
- Discussion by Dr. W. S. Middleton, Dean of the Medical School

November 5:
- Symposium on vitamins
  Drs. E. L. Sevringhaus, E. S. Gordon and C. A. Elvehjem

International Assembly of the Inter-State Postgraduate Medical Association of North America.—The Assembly will be held in the Public Auditorium, Cleveland, Ohio, October 14–18, and officers of the Inter-State Postgraduate Medical Association, the Academy of Medicine of Cleveland, the Cuyahoga County Medical Society and the Ohio State Medical Association extend a very cordial invitation to all members of the profession in good standing to attend. Attendants are urged to bring their ladies with them as a program is being arranged for their benefit by the Ladies' Committee.

A full program of scientific and clinical sessions will be presented each day and evening of the Assembly, starting at 8 a.m. An excellent opportunity is thus provided for an intensive week of postgraduate medical instruction by some eighty distinguished teachers and clinicians from various sections of the United States and Canada. A list of the speakers and further information concerning the program were given on page 784 of the September issue of this Journal. The registration fee for the scientific and clinical sessions will be $5.

BIRTHS

A daughter, Jane Helen, to Dr. and Mrs. J. J. Sazama, Bloomer, on August 20.

A son, James Martin, to Dr. and Mrs. T. J. Kroyer, Walworth, on August 12.

A son, George Edwin, III, to Dr. and Mrs. George Edwin Howe, Francis Creek, on August 7.

A son, Howard Scott, to Dr. and Mrs. V. L. Baker, Milwaukee, on September 2.

A son to Dr. and Mrs. S. S. Sorkin, Evansville, on September 8.

A son, James Reinhart, to Dr. and Mrs. C. R. Gilbertsen, Janesville, on September 7.

A daughter, Barbara Lenore, to Dr. and Mrs. L. B. Uszler, Milwaukee, on September 3.

A daughter, Mary Lory, to Dr. and Mrs. J. E. Szymarek, Milwaukee, on September 8.

MARRIAGES

Dr. D. W. McCormick, Madison, and Miss Margaret Ann King, Shawano, September 7.

Dr. L. H. Nowack, Watertown, and Miss Emma Hoge, Watertown, August 11.

Dr. J. K. Karr, Milwaukee, and Miss Mary Caroline Ielmini, Bessemer, Michigan, in August.

Dr. Helene N. Boyer, Racine, and Mr. Temple Neiter, Racine, August 24.

DEATHS

Dr. Merton E. Rideout, Waupaca, died on July 22 of a heart attack.

He was born in Hortonville, May 26, 1877. He was graduated from Northwestern Medical School, Chicago, in 1904, and practiced in Hortonville until

1933, when he became associated with the medical department of the Wisconsin Public Service Corporation. In March, 1940, he was appointed to the medical staff of the Veterans' Home, Waupaca.

The doctor served in France during the World War, holding the rank of captain in the medical corp.

He was a member of the Outagamie County Medical Society and the State Medical Society of Wisconsin. He was a Fellow of the American Medical Association. Surviving him are his wife, a son and a daughter.

Dr. Herman T. Schlegel, Wausau, died on July 9 of a heart ailment. He was 70 years of age.

He was graduated in 1909 from the Chicago College of Medicine and Surgery. In 1910 he opened his practice in Wausau where he specialized in the treatment of diseases of the eye, ear, nose and throat.

He served during the World War and held the rank of lieutenant. He was a member of the Marathon County Medical Society and the State Medical Society of Wisconsin; he was a Fellow of the American Medical Association. Surviving him are his widow and one daughter.

SOCIETY RECORDS

New Members

L. H. Donath, Lake Geneva.

V. J. Cordes, 1411 Wauwatosa Avenue, Wauwatosa.

C. S. Schneider, 744 West North Avenue, Milwaukee.

M. H. Steen, 19 Jefferson Avenue, Oshkosh.

H. A. Kennedy, Winneconne.

Bourne Jerome, 1507 Tower Avenue, Superior.

H. B. Christiansen, 2231 East Fifth Street, Superior.

D. H. Lando, Merrill.

T. E. Wyatt, Marshfield.

J. S. Vedder, Marshfield.

J. F. Poser, 955 Ludington Street, Columbus.

R. O. F. Poser, 955 Ludington Street, Columbus.

L. B. Perssion, Winnebago.

C. P. Kauth, Slinger.

Changes in Address

C. F. Rosenberg, Madison, to Wisconsin Veterans' Home, Waupaca.

F. C. Jacobson, Washburn, to 1422 Mound Street, Madison.

E. V. Brumbaugh, Milwaukee, to 430 North Lincoln Avenue, Beaver Dam.

W. J. Urben, Wauwatosa, to Mendota State Hospital, Mendota.

E. H. Pawsat, New York, to 104 South Main Street, Fond du Lac.

C. F. Sherman, Wichita, Kansas, to Veterans' Administration Hospital, Fayetteville, North Carolina.

W. O. Hendrickson, Pittsville, to Fairchild.

J. F. Kovacic, Milwaukee, to 925 North Eighth Street, Sheboygan.

C. P. Reslock, Fond du Lac, to Waupun.

H. K. Guth, Waupun, to New York Medical College, Flower and Fifth Avenue Hospitals, New York, New York.

H. S. Murphy, Kenosha, to 1642 Twenty-first Street, N. W., Washington, D. C.

M. A. Spalding, Milwaukee, to 345 Olympic Place, Seattle, Washington.

O. S. Blum, Chicago, to Grace Hospital, Welsh, West Virginia.

K. W. Davis, Green Bay, to Union Grove.

D. W. Calvy, Fond du Lac, to Elkhart Lake.

CORRESPONDENCE

ERROR CORRECTED

Green Bay, Wis., September 17, 1940.

Mr. J. G. Crownhart, Secretary,
State Medical Society of Wis.,
Madison, Wis.

Dear Mr. Crownhart: On page 649 of the August issue of the Wisconsin Medical Journal, Brown county is listed as having made no contribution of funds to the Women's Field Army of the American Society for the Control of Cancer. I telephoned our county captain, Mrs. J. M. Conway, Green Bay, and she reported that she sent $55.00 to the state headquarters at Horicon, Wis. This included the $1.00 memberships of twelve Green Bay doctors and two De Pere doctors. I obtained nine of these and I feel a responsibility in this regard, and would like to have a correction made in the next issue. I personally gave Mrs. Conway $9.00 for nine memberships and I am enclosing her statement in letter form.

Yours sincerely,
E. J. O'Brien, M.D.,
Secretary-Treasurer,
Brown–Kewaunee–Door County
Medical Society.

Madison, Wis., September 27, 1940.

E. J. O'Brien, M.D., Secretary,
Brown–Kewaunee–Door County Medical Society,
317 Dousman Street,
Green Bay, Wisconsin.

Dear Dr. O'Brien: Mrs. G. E. Stoddard of Horicon, State Chairman of the Women's Field Army of the American Society for the Control of Cancer, was in the office this morning and I told her about the letter from you relating to the Brown–Kewaunee–Door County contribution. She explained that the list they furnished for publication in the Journal was a preliminary list made up by the auditor as of July 1, as I recall it; that the contribution from the Brown–Kewaunee–Door Society came in subsequently, and that the amount as stated in your letter is quite correct. We are publishing your letter in the October issue of the Journal.

Very cordially yours,
J. G. Crownhart, *Secretary,*
State Medical Society of Wis.

1,700 Attend Ninety-Ninth Anniversary Meeting; Dr. Gunnar Gundersen of La Crosse Named President-Elect

IN THE second largest meeting ever held by the State Medical Society of Wisconsin, 50 per cent of the entire membership registered at the ninety-ninth anniversary meeting in Milwaukee on September 18, 19, and 20. Over 700 attended the thirty-five round table luncheons, and the main arena of the Milwaukee Auditorium was constantly crowded with members and guests visiting the eighty-five technical and scientific exhibits.

In its concluding session on Thursday morning the House of Delegates named as officers for the ensuing year the following: President-elect, Dr. Gunnar Gundersen of La Crosse; speaker, Dr. R. M. Kurten of Racine; vice-speaker, Dr. Charles Fidler of Milwaukee; delegates to the American Medical Association, Dr. S. E. Gavin of Fond du Lac (reelected) and Dr. J. C. Sargent of Milwaukee (reelected); alternate delegates, Dr. S. J. Seeger of Milwaukee (reelected) and Dr. F. E. Butler of Menomonie. Councilors were reelected as follows: third district, Dr. W. T. Clark of Janesville; fourth district, Dr. B. I. Pippin of Richland Center; fifth district, Dr. A. H. Heidner of West Bend; sixth district, Dr. S. E. Gavin of Fond du Lac; and twelfth district, Dr. Robert W. Blumenthal of Milwaukee.

Madison was selected as the city for the centennial meeting, which will be held on Wednesday, Thursday, and Friday, September 10, 11, and 12, 1941.

Over 110 papers were presented in the scientific sessions during the three days of the meeting, and 400 were in attendance at the annual dinner at which Dr. E. J. Carey, dean of Marquette University School of Medicine, gave the address.

Appointments of the President

Inaugurated as president at the conclusion of the Thursday evening meeting, Dr. R. P. Sproule of Milwaukee announced the appointment of Dr. A. S. Jackson of Madison as chairman of the special committee on the 1941 centennial meeting and also the following appointments to fill committee vacancies wherein terms expired:

Standing Committees

Committee on Cancer: Drs. E. F. Schneiders, Madison; Charles Fidler, Milwaukee; and Erich Wisiol, Stevens Point, reappointed. Dr. T. A. Teitgen, Manitowoc, to replace Dr. R. W. Hammond, Manitowoc. Dr. Fidler will serve as chairman.

Advisory Committee on Care of Crippled Children: Dr. J. O. Dieterle, Milwaukee, reappointed. Dr. H. C. Schumm, Milwaukee, to replace Dr. H. H. Christensen, Wausau.

Committee on Coordination of Medical Services: Dr. Millard Tufts, Milwaukee, to replace Dr. F. E. Butler, Menomonie. Dr. Tufts will serve as chairman.

Committee on Goiter: Dr. O. R. Lillie, Milwaukee, to replace Dr. J. H. Armstrong, New Richmond. Dr. Lillie will serve as chairman.

Committee on Grievances: Dr. W. A. Ryan, Milwaukee, to replace Dr. J. G. Taylor, Milwaukee. Dr. Ryan will serve as chairman.

Committee on Health and Public Instruction: Dr. W. J. Egan, Milwaukee, to replace Dr. E. J. Carey, Milwaukee. Dr. Egan will serve as chairman.

Committee on Industrial Health: Dr. W. W. Kelly, Green Bay, to replace Dr. T. J. O'Leary, Superior.

Committee on Maternal and Child Welfare: Dr. J. J. Pink, Milwaukee, to replace Dr. C. M. Echols, Milwaukee. Dr. Pink will serve as chairman. Dr. J. F. Wilkinson, Oconomowoc, to replace Dr. A. E. McMahon, Glenwood City.

Committee on Medical Economics: Dr. C. W. Eberbach, Milwaukee, to replace Dr. R. P. Sproule, Milwaukee. Dr. Eberbach will serve as chairman.

Committee on Medical Education and Hospitals: Dr. R. E. Burns, Madison, to replace Dr. I. R. Sisk, Madison.

Committee on Mental Hygiene and Institutional Care: Dr. S. K. Pollack, Milwaukee, to replace Dr. H. H. Christofferson, Colby. Dr. G. E. Seaman, Madison, will serve as chairman.

Committee on Public Policy: Dr. J. C. Sargent, Milwaukee, reappointed.

Council on Scientific Work: Dr. K. H. Doege, Marshfield, to replace Dr. J. A. Evans, formerly of La Crosse and now residing in Boston.

Committee on Tuberculosis and Chest Diseases: Dr. L. O. Simenstad, Osceola, reappointed.

Advisory Committee on Visual and Hearing Defects: Dr. F. W. Kundert, Madison, to replace Dr. W. M. Nesbit, Madison. Dr. J. K. Trumbo, Wausau, will serve as chairman.

Special Committees

Committee on Safety on Public Highways: Dr. M. W. Sherwood, Milwaukee, to replace Dr. Millard Tufts, Milwaukee. Dr. Sherwood will serve as chairman. Dr. J. J. Boersma, Sheboygan, to replace Dr. W. B. Cornwall, Amery. Dr. H. A. Heise, Milwaukee, reappointed.

Committee on Veneral Diseases: Dr. H. R. Foerster, Milwaukee, to replace Dr. I. R. Sisk, Madison. Dr. Foerster will serve as chairman. Dr. Conrad Giesen, Superior, to replace Dr. C. W. Giesen, Superior; Dr. N. W. Bourne, Milwaukee, to replace Dr. E. L. Tharinger, Milwaukee. Dr. Gunnar Gundersen, La Crosse, and Dr. Norbert Enzer, Milwaukee, reappointed.

Advisory Committee on Voluntary Sickness Insurance: The following is an excerpt from the recommendations of Dr. R. P. Sproule:

> "I am fully aware of the great sacrifices in time and effort that have been made by the present committee which consists of Dr. R. W. Blumenthal of Milwaukee, chairman; Dr. C. D. Neidhold of Appleton, and Dr. W. M. Nesbit of Madison. I know that each of these wishes to retire. Yet, in the name of a grateful Society, I feel that they must and will respond to a call for one additional year of public service. They have a fund of knowledge from actual experience that we cannot afford to lose. To lighten their effort, in reappointing the present members and chairman, I shall add to the committee Dr. Dexter Witte of Milwaukee whose service in a like field in Milwaukee County has been so outstanding."

Delegates Actions

When the House of Delegates convened on Tuesday evening, September 17, the speaker, Dr. J. N. Sisk, announced the appointment of the following reference committees:

Credentials

Dr. A. R. Tormey, Madison, chairman
Dr. A. G. Hough, Beaver Dam
Dr. W. S. Waite, Watertown

Reports of Officers and Standing Committees

Dr. Irwin Schulz, Milwaukee, chairman
Dr. Hugh Caldwell, Columbus
Dr. D. J. Twohig, Fond du Lac
Dr. S. L. Henke, Eau Claire
Dr. G. C. Schulte, Kenosha

Resolutions

Dr. W. D. Stovall, Madison, chairman
Dr. Charles Fidler, Milwaukee
Dr. L. O. Simenstad, Osceola
Dr. A. A. Cantwell, Shawano
Dr. P. R. Minahan, Green Bay

Amendments to the Constitution and By-Laws

Dr. J. W. Boren, Marinette, chairman
Dr. E. H. Spiegelberg, Boscobel
Dr. W. M. Trowbridge, Viroqua
Dr. E. D. Sorenson, Elkhorn

Report of the Council

Dr. K. H. Doege, Marshfield, chairman
Dr. W. A. Munn, Janesville
Dr. J. C. Griffith, Milwaukee
Dr. J. W. Prentice, Ashland
Dr. R. M. Kurten, Racine

The Tuesday evening session was devoted to extensive presentations by officers and committee chairmen, following which the House voted fifty-six to one to reject a proposed amendment to the constitution which provided for the election of councilors at district meetings instead of by the House after nomination coming from a caucus of delegates from societies in the affected district. In subsequent sessions of the House held in the Auditorium of Marquette University School of Medicine on Wednesday evening and in the Schroeder Hotel on Thursday morning discussions were held on reports and recommendations that had been placed in the hands of delegates before they came to Milwaukee. The following actions were outstanding:

1. Adopted a report of the Council.

2. Adopted five clarifying amendments to the by-laws, one of which specifies how sections may be created.

3. Paid tribute to the high service of the retiring speaker, Dr. J. N. Sisk of Madison.

4. By vote of twenty-six to twenty-two referred to the Council for subsequent report the amendment concerning the duties of county societies with respect to tax-

exempt hospitals that are the only means of serving an area.

5. Adopted a resolution of Dr. W. A. Munn of Janesville calling for a special committee to study the problem of supplying nurses whose training is emphasized by its vocational character.

6. Referred to committees of the Society the recommendations of the incoming president for (a) a restudy of daylight saving legislation, (b) a reminder to hospital boards of trustees and directors concerning the fulfillment of their corporate powers and responsibilities in hospital management, (c) a recommendation that hospital superintendents should be physicians wherever possible.

7. Referred to committees of the Society recommendations of the retiring president and in particular that concerning annual reregistration of physicians.

8. Adopted a special report of the Committee on Industrial Health advocating greatly extended activities of the Society to promote pre-employment and periodic health examinations in industry under the plan of free choice of physician from panels prepared by the Society.

9. Adopted the supplementary report of the Advisory Committee on Voluntary Sickness Insurance empowering the president to continue the committee during the ensuing year, setting forth its duties, stating the Society's policy with reference to the continuation of the two present trials in Douglas and Milwaukee Counties, and declaring it to be the Society's policy that in any plan that may subsequently eventuate as feasible, sales and sales effort shall be handled distinct from all other groups or agencies.

10. Adopted a report of the Committee on Public Policy in which its needs for the ensuing year were set forth in some detail.

11. After holding detailed budget hearings, established the dues for the ensuing year as $15 with a $10 assessment.

12. Adopted a special resolution proposed by Dr. R. E. Fitzgerald, chairman of the M–Day Committee, calling upon all members to assist in preserving the practices of those physicians responding to military duty during mobilization.

W. D. Stovall, M. D.
Recipient of 1940 Council Award.

13. Adopted a special resolution relating to specialist relations in hospitals and creating special committee leaders to accomplish its purposes through the Society office.

Council Award

The sixteenth presentation of the Council Award since its establishment eleven years ago was bestowed upon Dr. W. D. Stovall of Madison on the occasion of the annual dinner on September 19. Dr. S. E. Gavin, Fond du Lac, chairman of the Council, made the presentation, saying:

"The highest honor in the power of the State Medical Society of Wisconsin to bestow upon one of its members is The Council Award. It is granted but on occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, and their fellow physicians, and the public. In the ten years since The Council Award was established, fifteen awards have been made. Tonight we give another.

"William Davison Stovall a son of Mississippi of the fourth generation of physicians; distinguished as a bacteriologist and pathologist; a teacher whose example has

been an inspiration to another generation of physicians; for a quarter of a century acting director and director of our State Laboratory of Hygiene; two years acting superintendent of the Wisconsin General Hospital; successively Secretary, Vice-President, President, and Trustee of the Dane County Medical Society; ten years chairman of the Committee on Cancer of the State Medical Society of Wisconsin, earlier chairman of its Committee on Health and Public Instruction, several terms a member of its House of Delegates and Speaker of that body in 1931; committee chairman of the American Public Health Association, and state chairman and director of the American Society for the Control of Cancer,—for your attainments in the field of science; for your public service in hygiene and preventive medicine as coordinator of physicians, public, and state in joint action that has brought new health records to our citizenry through the greatest of all public health forces—an alert army of capable physicians and an educated public; for your furtherance of the aims of your Society; and for your unswerving allegiance and devotion to the maintenance and building of the untrammeled general practitioner of medicine as the foundation of an unconquerable and inspired American medicine, we, your fellow members, give you this seal of our Society as a token of your achievement and of our esteem and affection."

Golf Tournament

Dr. G. R. Love of Oconomowoc won the "Dr. E. W. Miller" low gross trophy in the annual golf tournament of the State Society, held September 17 at the Ozaukee Country Club. Dr. Love's score was 76, and Dr. J. G. Garland, one time winner, was runner-up with a 77.

The secretary's cup and a permanent trophy went to Dr. H. J. Cannon with a low net score of 68.

Forty-three prizes were then distributed in a blind hole, net total bogey. Ten prizes in the cash blind bogey went to Drs. M. F. Drozewski, G. E. Meloy, A. H. Hermann, W. F. Grotjan, P. B. Mason, E. F. McGrath, K. W. Covell, T. M. Slemmons, K. E. Lemmer, and M. H. Seevers.

Day-By-Day List of Members Registered at Annual Meeting in Milwaukee, September, 1940

Wednesday, September 18

Abelmann, T. C. H. ----Watertown
Adams, R. W. ----------Chetek
Adamski, A. W. ----------Racine
Allen, Jessie ----------Beloit
Allen, W. J. ----------Beloit
Ansfield, Maurice J. ---Milwaukee
Archer, W. E. ----------Appleton
Armbruster, J. L. ------Milwaukee
Armstrong, C. A. -Prairie du Chien
Arnoldussen, C. P. -------Fremont
Arveson, R. G. ----------Frederic
Aylward, T. J. --------Milwaukee

Bachhuber, Max ----------Alma
Baer, C. A. ----------Milwaukee
Baker, Rowe G. -------Tomahawk
Banyai, A. L. --------Wauwatosa
Bardenwerper, H. E. --Milwaukee
Barnes, J. Steele ------Milwaukee
Barta, E. F. ----------Milwaukee
Bartels, G. W. ---------Janesville
Batty, A. J. ----------Portage
Bauer, K. T. ----------West Bend
Beck, A. A. ----------Wautoma
Becker, Walter T. -----Milwaukee
Beckman, Harry ------Milwaukee
Behnke, Edgar J. ------Milwaukee
Belknap, E. L. --------Milwaukee
Bellehumeur, C. E. ----Milwaukee
Belting, G. W. --------Orfordville
Bender, B. I. ----------Milwaukee
Benjamin, H. B. ------Wauwatosa
Bennett, L. J. --Wisconsin Rapids
Bennett, W. H. ----------Kenosha
Bensman, L. L. --------Milwaukee
Bercey, J. E. ----------Milwaukee
Bernhard, L. A. -------Milwaukee
Bernhart, E. L. --------Milwaukee
Bickler, E. P. ---------Milwaukee
Biehn, Ralph H. ------Wauwatosa
Biller, J. H. ----------Milwaukee
Biller, S. E. ----------Milwaukee
Binnewies, F. C. -------Janesville
Bitter, R. H. ----------Oshkosh
Blanchard, P. B. ------Cedarburg
Blount, W. P. ---------Milwaukee
Blumenthal, Robert W. Milwaukee
Bohorfoush, J. G. --------Madison
Boren, J. W. ----------Marinette
Borman, M. C. ---------Milwaukee
Bornstein, S. L. -------Milwaukee
Bourne, N. Warren ----Milwaukee
Bowen, H. P. ---------Watertown
Boyd, C. D. ----------Kaukauna
Boyd, George L. -------Kaukauna
Brachman, Louis ------Milwaukee
Brey, P. F. ----------Milwaukee
Brown, G. V. I. --------Milwaukee
Browne, C. F. ----------Racine
Bruins, Dirk ----------Milwaukee
Brunkhorst, R. O. ----Milwaukee
Brussock, W. A. ------Wauwatosa
Bryan, A. W. ----------Madison
Brzezinski, E. A. ------Milwaukee
Buckley, R. A. --------Eau Claire
Buckley, W. E. ----------Racine
Budny, C. L. ----------Milwaukee
Bump, Warner S. ----Rhinelander
Butler, F. E. ---------Menomonie
Byrnes, M. B. ---------Milwaukee

Cahana, Stephen ------Milwaukee
Cairns, Rolla --------River Falls
Caldwell, H. M. --------Columbus
Callan, P. L. ----------Milwaukee
Canavan, J. P. ----------Neenah
Cantwell, A. A. ---------Shawano
Carey, Eben J. --------Milwaukee
Carhart, G. A. --------Milwaukee
Carney, C. M. ----------Beloit
Carson, W. J. ---------Milwaukee
Carter, R. M. ----------Green Bay
Ceci, G. E. ----------Milwaukee
Champney, R. D. ------Milwaukee
Charles, J. D. ---------Milwaukee
Christensen, F. C. ---------Racine

Christensen, H. H. ------Wausau
Christiansen, C. H. -----Superior
Christofferson, H. H. -------Colby
Clark, F. T. ----------Waupun
Clark, W. T. ----------Janesville
Cleveland, David -----Milwaukee
Comstock, Elizabeth ----Arcadia
Conroy, C. F. ---------Milwaukee
Constantine, C. E. --------Racine
Conway, J. P. ---------Milwaukee
Coon, H. M. ----------Statesan
Cooper, G. A. ----------Madison
Cordes, V. J. ---------Wauwatosa
Couch, T. T. ----------West Allis
Creasy, L. E. ----------Monroe
Crigler, R. R. ---South Milwaukee
Cron, R. S. ----------Milwaukee
Crowe, Neal F. ----------Delavan
Curran, W. P. ----------Antigo
Currer, P. M. ---------Milwaukee
Curtin, J. G. ----------Milwaukee

Daniels, E. R. ------Wauwatosa
Davies, R. E. ----------Waukesha
Dawson, C. A. --------River Falls
Dawson, D. L. ---------Rice Lake
De Fazio, S. F. ---------Kenosha
Dehne, W. O. ----------Appleton
Demeter, N. D. --------Milwaukee
Devine, G. C. ----------Ontario
Deysach, L. J. --------Milwaukee
Dieterle, J. O. ---------Milwaukee
Dockery, G. A. -------Franksville
Docter, J. C. ----------Racine
Dodd, J. M. ----------Ashland
Doege, K. H. ----------Marshfield
Drexel, A. ----------Milwaukee
Drozewski, M. F. -----Milwaukee
Duer, G. R. ----------Marinette
Dull, C. F. -------Richland Center
Dundon, J. R. ---------Milwaukee
Dunn, A. G. --------Stevens Point
Durner, U. J. ---------Milwaukee

Eagan, R. L. ----------La Crosse
Eberbach, C. W. -------Milwaukee
Echols, C. M. ---------Milwaukee
Edwards, A. C. ----------Baraboo
Egan, W. J. ----------Milwaukee
Egloff, L. W. ----------Pewaukee
Eisenberg, Ed. --------Milwaukee
Eisenberg, J. J. -------Milwaukee
Eisenberg, P. J. -------Milwaukee
Elbe, T. D. ----------Thiensville
End, Edgar M. --------Milwaukee
Enzer, Norbert --------Milwaukee
Epperson, P. S. -------Milwaukee
Ewell, G. H. ----------Madison

Farnsworth, F. B. ------Janesville
Fauerbach, Louis --------Madison
Fazen, L. E. ----------Racine
Feasler, C. H. --------Winnebago
Federspiel, M. N. ------Milwaukee
Feiman, L. H. ---------Milwaukee
Feldt, R. H. ----------Milwaukee
Fellman, G. H. --------Milwaukee
Fernan-Nunez, M. ----Milwaukee
Fetherston, J. P. -----Milwaukee
Fidler, Charles -------Milwaukee
Fiedler, Otho ---------Sheboygan
Finn, W. C. ---------Fond du Lac
Fisher, R. S. ----------Allenton
Fitzgerald, G. F. ------Milwaukee
Fitzgerald, R. E. ------Milwaukee
Flaherty, G. S. --South Milwaukee
Flanagan, G. J. --------Kaukauna
Foerster, H. R. -------Milwaukee
Foley, L. J. ----------Milwaukee

Fons, J. W. ----------Milwaukee
Forman, Judson -------Mt. Horeb
Fosmark, C. A. ----------Madison
Francois, S. J. A. ----New Glarus
Franklin, I. ----------Milwaukee
Frawley, D. D. --------Milwaukee
Frederick, R. H. ------West Allis
Freitag, S. A. ----------Janesville
Frey, P. G. ----------Milwaukee
Frisch, R. A. ----------Milwaukee
Friske, O. W. ----------Beloit
Froelich, J. A. --------Milwaukee
Furlong, J. J. -----Whitefish Bay
Fuson, H. S. ----------Eau Claire

Gabor, M. E. ----------Milwaukee
Galasinski, R. E. ------Milwaukee
Gallagher, E. E. -------La Crosse
Gallaher, D. M. ---------Appleton
Ganzer, W. J. ----------Madison
Garens, R. W. ---------Milwaukee
Garland, J. G. ---------Milwaukee
Garrison, R. E. -Wisconsin Rapids
Garvey, J. L. ----------Milwaukee
Gebhard, U. E. ---------Milwaukee
Gertenbach, E. O. -----Milwaukee
Gilchrist, R. T. ---------Milwaukee
Gilmer, L. T. ----------Milwaukee
Glynn, J. D. ----------Lancaster
Goggins, J. W. ----------Chilton
Goodman, J. S. --------Milwaukee
Goodman, P. P. ---------Milwaukee
Gramling, E. H. -------Milwaukee
Gramling, H. J. -------Milwaukee
Gramling, J. J. --------Milwaukee
Gramling, J. J., Jr. ----Milwaukee
Grant, R. S. ----------Racine
Greenberg, A. I. ------Milwaukee
Greene, H. L. ----------Madison
Griffith, J. C. ----------Milwaukee
Grill, John ----------Milwaukee
Grossmann, L. L. ------Milwaukee
Grotjan, W. F. ---------Milwaukee
Ground, W. E. ----------Superior
Grove, W. E. ---------Milwaukee
Gudex, V. A. --------Fond du Lac
Guenther, O. F. ---Campbellsport
Gundersen, Alf --------La Crosse
Gute, E. B. ----------Milwaukee

Habeck, E. A. ----------Milwaukee
Haberland, J. E. ------Milwaukee
Haessler, B. T. ---------Milwaukee
Hagerman, F. H. ------Milwaukee
Hahn, P. R. ----------Racine
Hammond, F. W. ------Manitowoc
Hankwitz, A. W. ------Milwaukee
Hansen, A. C. ---------Milwaukee
Hansher, Ervin -------Milwaukee
Hansmann, G. H. ------Milwaukee
Harder, H. ----------Milwaukee
Hardgrove, Maurice ---Milwaukee
Hassall, J. C. -------Oconomowoc
Hatleberg, C. N. B. Chippewa Falls
Haushalter, H. P. -----Milwaukee
Heeb, H. J. ----------Milwaukee
Hefke, H. W. ----------Milwaukee
Heidner, A. H. --------West Bend
Heidner, F. C. ---------Milwaukee
Heifetz, E. V. ---------Milwaukee
Heise, H. A. ----------Milwaukee
Hemmingsen, T. C. -------Racine
Henke, S. L. ----------Eau Claire
Henken, J. F. ----------Racine
Hermann, A. H. -------Milwaukee
Herzog, J. V. ---------Milwaukee
Higgins, S. G. ---------Milwaukee
Hildebrand, G. J. ------Sheboygan

Hilger, W. A. ---------Milwaukee
Hiller, R. I. ----------Milwaukee
Hiller, S. J. ----------Milwaukee
Hipke, L. W. ----------Milwaukee
Hirsh, L. H. ----------West Allis
Hoermann, B. A. ------Milwaukee
Hoffmann, J. G. ---------Hartford
Hoffmann, L. A. ---Campbellsport
Holmgren, L. E. ---------Madison
Horwitz, J. J. ---------Milwaukee
Hougen, E. T. ----------Oostburg
Hough, A. G. --------Beaver Dam
Hoyt, G. E. -----Menomonee Falls
Hunter, A. L. ----------Madison
Hurth, O. J. ----------Cedarburg
Hurth, O. W. ----------Cedarburg
Huston, John ---------Milwaukee
Huth, M. F. ----------Baraboo

Irvine, R. K. ----------Manawa
Irwin, G. H. ----------Lodi
Irwin, R. S. ----------Milwaukee
Ison, G. W. ----------Crandon

Jackson, A. S. ----------Madison
Jackson, Edward ------Milwaukee
Jacobson, E. B. --------Milwaukee
James, W. D. -------Oconomowoc
Jamieson, R. D. ----------Racine
Janney, F. R. ---------Wauwatosa
Jekel, J. M. ----------Milwaukee
Jermain, W. M. -------Milwaukee
Johnson, A. W. ----Hales Corners
Johnson, F. G. --------Iron River
Johnson, Frances ------Milwaukee
Johnson, J. H. ---------Milwaukee
Johnson, K. F. ---------Frederic
Jones, M. L. ----------Wausau
Joseph, W. A. ---------Milwaukee

Kahn, Joseph ---------Milwaukee
Kaiser, L. F. ---------Rhinelander
Karr, J. K. ----------Milwaukee
Kassowitz, K. E. ----Wauwatosa
Kasten, H. E. ----------Beloit
Kastner, A. L. ---------Milwaukee
Kaufman, L. W. ------Milwaukee
Kearns, W. M. ---------Milwaukee
Keland, H. B. ----------Racine
Kelley, F. H. ----------Merrill
Kelley, J. F. ----------Janesville
Kelly, G. F. ----------Milwaukee
Kettelhut, E. J. -------Milwaukee
Kilbourne, B. C. ------Milwaukee
Kilian, A. D. ----------Milwaukee
Kilkenny, G. S. -------Milwaukee
King, J. J. ----------Milwaukee
King, J. M. ----------Milwaukee
Kishpaugh, H. W. ---------Beloit
Kleinboehl, J. W. -----Milwaukee
Klepfer, J. F. ----------Waupun
Kline, C. L. ----------Racine
Knauf, A. J. ----------Sheboygan
Koch, H. C. ----------Berlin
Koch, V. W. ----------Janesville
Kocovsky, E. C. -------Milwaukee
Koehler, A. G. ----------Oshkosh
Koehler, J. P. ---------Milwaukee
Kohn, S. E. ----------Milwaukee
Konnak, W. F. ----------Racine
Kovacs, Arthur -------Milwaukee
Kozina, Frank J. ------Milwaukee
Kradwell, W. T. -----Wauwatosa
Kramoris, F. H. -------Milwaukee
Kretchmar, Morris ----Milwaukee
Kretlow, F. A. ---------Milwaukee
Kreul, R. W. ----------Racine
Kriz, G. A. ----------Milwaukee
Kriz-Hettwer, R. A. --Milwaukee

Kronzer, J. J. ----------Oshkosh
Kroyer, T. J. ----------Walworth
Krueger, B. ----------Cudahy
Krygier, W. L. --------Milwaukee
Krzysko, S. L. --------Milwaukee
Kuhn, H. J. ----------Milwaukee
Kuhn, M. J. ----------Milwaukee
Kult, A. S. ----------Milwaukee
Kurten, R. M. ----------Racine
Kwapy, C. R. ----------Oconto

Lademan, O. E. --------Milwaukee
Ladewig, A. W. -------Milwaukee
Laird, J. J. ----------Black Creek
Lando, D. H. ----------Merrill
Lando, D. H., Jr. ------Milwaukee
Lang, V. F. ----------Milwaukee
Langjahr, A. R. ------Milwaukee
Lavine, I. H. ----------Melrose
Leahy, J. D. ----------Park Falls
Lee, Paul A. ----------Milwaukee
Lemmer, K. E. ----------Madison
Lettenberger, J. -------Milwaukee
Lifschutz, L. M. ----------Racine
Lindner, A. M. ----------Racine
Lipman, W. H. ----------Kenosha
Littig, L. V. ----------Madison
Long, C. W. ----------Milwaukee
Ludwig, E. P. ----------Wausau
Lungmus, B. A. -------Milwaukee

Macaulay, E. M. ---------Wausau
Mackoy, F. W. --------Milwaukee
MacCollum, C. L. R. --Manitowoc
MacInnis, Florence ----Milwaukee
MacRae, M. F. --------Milwaukee
Mallow, H. G. E. ------Watertown
Malloy, T. E. ------Random Lake
Malnekoff, B. J. ------Milwaukee
Malone, J. Y. ----------Milwaukee
Maloof, G. J. ----------Madison
Mann, Robert W. ------Milwaukee
Marek, F. B. ----------Racine
Margoles, F. C. -------Milwaukee
Margoles, Milton ------Milwaukee
Marshall, V. F. ---------Appleton
Martin, H. G. ---------Milwaukee
Martineau, E. L. ------Milwaukee
Mason, E. W. ---------Milwaukee
Mason, R. W. ---------Marshfield
May, J. V. ----------Marinette
Mayfield, A. L. ----------Kenosha
McCabe, J. O'D. -------Milwaukee
McCann, Edith --------Milwaukee
McCormick, S. A. --------Madison
McDonald, R. E. ------Milwaukee
McGarty, M. A. ---------La Crosse
McKillip, W. J. -------Milwaukee
McMahon, F. B. -------Milwaukee
McMahon, H. O. ------Milwaukee
McNary, J. F. --------Milwaukee
Meany, S. G. ----------East Troy
Megna, J. A. ----------Milwaukee
Mellencamp, F. J. ------Milwaukee
Merten, A. N. E. ------Milwaukee
Meusel, H. H. ----------Oshkosh
Milchen, Carl ----------Blair
Millard, A. L. ----------Marshfield
Miller, E. A. ---------Clintonville
Miller, E. A. ----------Watertown
Miller, E. W. ---------Milwaukee
Miller, H. C. ----------Racine
Miller, H. L. ----------Milwaukee
Minahan, P. R. --------Green Bay
Mollinger, S. M. ------Milwaukee
Molsberry, J. M. ------Milwaukee
Monroe, Maurice --------Hartford
Morrison, D. A. R. --Oconomowoc

Morse, L. M. -------Stevens Point
Morter, C. W. ---------Milwaukee
Morton, S. A. ---------Milwaukee
Mudroch, J. A. ---------Columbus
Munn, W. A. ----------Janesville
Murphy, J. A. ---------Milwaukee
Murphy, J. H. --------Clintonville

Nadeau, A. T. ----------Marinette
Natenshon, A. L. ------Milwaukee
Nebel, Harold ---------Milwaukee
Neidhold, Carl ----------Appleton
Nereim, T. J. ----------Whitehall
Neville, Mary E. ------Milwaukee
Nichols, Charles H. ----Milwaukee
Niland, P. J. ----------Milwaukee
Noble, J. B. ----------Waukesha
Norton, D. M. ----------Medford

Oakland, H. G. --------Milwaukee
Oberbreckling, P. E. --Milwaukee
Oberfeld, Harold H. ---Milwaukee
O'Brien, E. J. ---------Green Bay
O'Donnell, S. P. ----------Kiel
O'Leary, Mary Joan ---Milwaukee
O'Leary, T. J. ----------Superior
Olson, H. J. ----------Milwaukee
Olson, L. C. J. ----------Delafield
Olson, W. A. ---------Greenwood
O'Malley, W. P. -------Milwaukee
O'Neal, Orvil ----------Ripon
O'Neill, E. J. ---------Milwaukee
Ovitt, D. W. ----------Milwaukee

Panetti, H. E. --------Milwaukee
Park, C. F. ----------Milwaukee
Parke, George ----------Viola
Patek, A. J. ----------Milwaukee
Patterson, L. G. --------Waupaca
Pechous, C. E. ----------Kenosha
Pegram, J. W. --------Milwaukee
Perlson, P. H. --------Milwaukee
Peterman, M. G. ------Milwaukee
Peterson, L. W. ------Sun Prairie
Pfeffer, T. J. ----------Racine
Pfeifer, E. C. ----------Racine
Pfeifer, H. A. ---------Milwaukee
Piaskoski, Ray --------Milwaukee
Pierce, D. F. ------Hales Corners
Pippin, B. I. ----Richland Center
Pleyte, A. A. ----------Milwaukee
Pollack, S. K. --------Milwaukee
Pomainville, H. G. -------Nekoosa
Pomainville, L. C. Wisconsin Rapids
Pope, F. W. ----------Racine
Popp, Albert ----------Milwaukee
Powers, H. W. --------Milwaukee
Prentice, J. W. ----------Ashland
Pugh, G. J. ----------Milwaukee
Purtell, R. F. ---------Milwaukee

Quackenbush, Earl C. -Iron Ridge

Raine, Forrester ------Milwaukee
Randall, M. W. -------Blue River
Rank, Ralph T. -------Milwaukee
Raube, H. A. ----------Beloit
Rector, A. E. ----------Appleton
Rees, Thomas H. ------Manitowoc
Reinke, C. C. ---------Milwaukee
Reuter, M. J. ---------Milwaukee
Reznichek, C. G. --------Madison
Riehl, F. W. ----------Milwaukee
Ries, M. F. ----------Brownsville
Rife, C. S. ----------Milwaukee
Ringo, H. F. ----------Montreal
Ripley, H. M. ----------Kenosha
Robbins, J. M. --------Milwaukee
Rogers, E. H. ---------Milwaukee

Rogers, R. B. ----------Neenah
Rolfs, T. H. ----------Milwaukee
Rosekrans, M. C. ------Neillsville
Rosenberger, A. I. ----Milwaukee
Ross, G. L. ----------Racine
Roth, W. C. ----------Racine
Ruppenthal, A. J. ------Milwaukee
Ruschhaupt, L. F. ----Milwaukee
Russell, F. H. ---------West Allis
Russell, J. A. ------Random Lake
Russell, R. J. M. ------Milwaukee
Ryan, Edward R. ------Milwaukee
Ryan, William A. -----Milwaukee

Sadoff, H. B. ----------Milwaukee
Sander, O. A. ----------Milwaukee
Sargent, James C. ----Milwaukee
Sass, Laurence C. -----Milwaukee
Savage, G. T. ---------Milwaukee
Schacht, E. W. ----------Racine
Schacht, R. J. ----------Racine
Schade, Robert E. ----Milwaukee
Schaefer, A. A. -------Milwaukee
Schelble, E. J. --------Milwaukee
Schelble, John P. -----Milwaukee
Schlaepfer, Karl ------Milwaukee
Schlomovitz, B. H. ----Milwaukee
Schlomovitz, E. H. ----Milwaukee
Schlossmann, B. -------Milwaukee
Schmidt, H. G. --------Milwaukee
Schmidt, J. A. ---------Milwaukee
Schneider, C. C. -------Milwaukee
Schneider, C. S. -------Milwaukee
Schneller, E. J. ----------Racine
Schoen, C. M. ---------Milwaukee
Schoenkerman, B. B. --Milwaukee
Schoofs, O. P. ---------Milwaukee
Schowalter, R. P. -----Milwaukee
Schuldt, C. M. ---------Platteville
Schuler, F. X. --------Milwaukee
Schulte, G. C. ----------Kenosha
Schulz, G. J. --------Union Grove
Schulz, Irwin ---------Milwaukee
Schumacher, H. S. ----Milwaukee
Schumm, H. C. --------Milwaukee
Schutte, A. G. ---------Milwaukee
Schwittay, A. M. --------Madison
Scollard, W. J. --------Milwaukee
Seaman, G. E. ----------Madison
Seegers, F. W. ---------Milwaukee
Senn, U. ----------Milwaukee
Seymer, L. A. --------Wauwatosa
Shapiro, A. M. --------Milwaukee
Shaw, R. W. ----------Marinette
Sherwood, M. W. ------Milwaukee
Shimpa, J. F. ---------Milwaukee
Shutkin, Michael ------Milwaukee
Siekert, H. P. ---------Milwaukee
Silbar, S. J. ----------Milwaukee
Simenstad, L. O. ----------Osceola
Simons, N. S. ----------Whitehall
Sincock, H. A. ----------Superior
Sisk, Ira ----------Madison
Sisk, J. N. ----------Madison
Sivyer, A. W. ---------Milwaukee
Slemmons, T. M. --------Waupun
Slutzky, Nathan ------Milwaukee
Smiles, C. J. ----------Ashland
Smith, H. S. ----------Cudahy
Smith, J. F. ----------Wausau
Smith, J. W. ----------Milwaukee
Smith, L. D. ----------Milwaukee
Smith, T. D. ----------Neenah
Smith, Woodruff ------Ladysmith
Smits, R. H. ----------West Allis
Smuckler, R. H. -------Milwaukee
Sobush, L. D. ---------Manitowoc
Soles, F. A. ----------Platteville

Sorenson, E. D. ----------Elkhorn
Spiegelberg, E. H. ------Boscobel
Spitz, M. M. ----------Milwaukee
Sprague, L. V. ----------Madison
Sproule, R. P. --------Milwaukee
Squier, T. L. ----------Milwaukee
Stadel, E. V. ----------Reedsburg
Stahmer, A. H. ----------Wausau
Stamm, L. P. ---------Milwaukee
Steckbauer, J. W. ------Manitowoc
Steele, J. D., Jr. ------Milwaukee
Stemper, I. G. ------Oconomowoc
Stern, C. S. ----------West Allis
Stern, Louis ----------Milwaukee
Stevens, G. H. ----------Wausau
Stiennon, O. A. --------Green Bay
Stirn, F. J. ----------Milwaukee
Stoddard, C. H. --------Milwaukee
Stovall, W. D. ----------Madison
Stranberg, W. L. ------West Allis
Strauch, C. B. ---------Milwaukee
Suhr, A. L. ----------Milwaukee
Sullivan, James M. ----Milwaukee
Sullivan, Walter ---------Madison
Sverdlin, A. A. --------Milwaukee

Tabachnick, Harry ----Milwaukee
Tegtmeyer, G. F. -----Milwaukee
Tessier, A. F. ---------Milwaukee
Theisen, S. A. ------Fond du Lac
Thill, G. E. ----------Milwaukee
Thompson, I. F. ----------Racine
Thompson, F. A. ------Milwaukee
Tomkiewicz, Nina -----Milwaukee
Topp, C. A. ----------Clintonville
Tormey, A. R. ----------Madison
Tousignant, A. N. ---------Oconto
Treskow, Frank G. ----Milwaukee
Trowbridge, W. M. ------Viroqua
Troxel, J. C. ----------Appleton
Truitt, J. W. ---------Milwaukee
Tucker, I. N. ----------Racine
Tufts, Millard --------Milwaukee
Twohig, D. J. -------Fond du Lac

Urdan, B. E. ----------Milwaukee

Van Kirk, F. W. -------Janesville
Van Valin, E. C. ----------Sussex
Verdone, A. J. --------Milwaukee
Virgin, H. W., Jr. -------Madison
Vogel, T. L. ------Milton Junction

Wagner, W. A. ----------Oshkosh
Waite, W. S. ---------Watertown
Waldman, I. J. --------Milwaukee
Walter, G. W. ----------Racine
Walton, W. B. --------Milwaukee
Warschauer, B. -------Milwaukee
Watkins, W. C. ----------Oconto
Weber, C. J. ----------Sheboygan
Weber, F. T. ----------Arcadia
Wegmann, N. J. ------Milwaukee
Weingart, W. F. ------Milwaukee
Weinshel, L. R. -------Milwaukee
Weisfeldt, L. A. -------Milwaukee
Weisfeldt, S. C. -------Milwaukee
Weller, E. A. --------Weyauwega
Wenn, J. F. ----------Milwaukee
Wenstrand, D. E. W. --Milwaukee
Werrell, W. A. ----------Madison
Wesche, G. E. ----------Hayward
Whalen, G. E. ---------Milwaukee
Wheeler, W. P. ----------Oshkosh
White, A. S. ----------Rice Lake
Wieder, L. M. ---------Milwaukee
Wiese, M. E. J. --------Milwaukee
Wigod, David ---------Waterford
Wilets, J. C. ----------Milwaukee
Wilker, W. F. ----------Iola
Willett, Thomas ------West Allis
Williams, S. E. --Chippewa Falls
Williamson, G. H. --------Neenah
Wilson, R. F. ----------Belolt
Winter, A. E. ----------Tomah
Wiswell, C. Y. ----Williams Bay
Witte, D. H. ----------Milwaukee
Wolf, R. C. --------Hales Corners
Woodhead, F. J. ------Waukesha
Wright, H. H. --------Milwaukee
Wyatt, T. E. ----------Marshfield
Wyman, J. F. ---------Milwaukee

Yockey, J. C. -------Fond du Lac
Young, A. F. ----------Milwaukee
Young, J. H. ----------Elkhorn

Zellmer, C. E. ----------Antigo
Ziegler, L. H. --------Wauwatosa
Zillmer, Helen J. ------Milwaukee
Zivnuska, J. F. -------Milwaukee
Zlatnik, A. P. --------Two Rivers
Zuercher, J. C. --------Milwaukee
Zurheide, H. O. -------Milwaukee

Thursday, September 19

Ackerman, E. T. ------Gays Mills
Alcorn, M. W. --------Burlington
Allebach, H. K. B. ----Milwaukee
Allen, J. S. ----------Norwalk
Allen, S. C. ----------Waterloo
Altenhofen, A. R. ----Wauwatosa
Andrew, C. H. ---------Platteville
Ansfield, D. J. ---------Milwaukee
Augur, A. ----------Milwaukee

Bach, M. J. ----------Milwaukee
Baldwin, F. H. ------Bloomington
Baldwin, R. S. ---------Marshfield
Bane, H. W. ----------Beloit
Baranowski, S. A. -----Milwaukee
Barnes, H. T. ----------Delafield
Barrock, J. J. ---------Milwaukee
Baum, E. L. ----------Milwaukee
Baumle, C. E. ----------Monroe
Beatty, S. R. ----------Oshkosh
Becker, W. C. --------Watertown
Beebe, C. D. ----------Sparta
Beebe, D. C. ----------Sparta
Beeson, H. B. ----------Racine
Benn, H. P. --------Stevens Point
Benn, V. H. ----------Rosholt
Bentzien, E. W. -------Milwaukee
Bergen, R. D. --------Milwaukee
Bertolaet, E. E. ---------Palmyra
Biljan, M. W. ---------West Allis
Binnie, Helen ----------Kenosha
Birk, B. J. ----------Milwaukee
Blanchard, H. H. ------Milwaukee
Blankstein, S. S. ------Milwaukee
Bolles, C. S. ----------De Pere
Bolton, E. L. ----------Appleton
Boner, A. J. ----------Madison
Boudry, M. O. ----------Waupaca
Bowing, Irwin ----------Kenosha
Boxer, L. M. ----South Milwaukee
Boyer, H. N. ----------Racine
Brady, C. J. --------Lake Geneva
Brickbauer, A. J. ------Plymouth
Brindley, B. I. ----------Madison
Bristow, J. H. ----------Monroe
Broderick, C. F. ------Milwaukee
Brook, J. J. ----------Milwaukee
Brooks, E. H. ----------Appleton
Brunckhorst, F. O. --------Neenah
Burbach, T. H. --------Milwaukee
Burgardt, G. F. -------Milwaukee
Burke, C. F. ----------Madison
Burkhardt, E. W. Menomonee Falls
Burns, R. E. ----------Madison
Busse, A. A. ----------Jefferson
Bussewitz, M. A. ------Milwaukee

Campbell, P. E. -------Waukesha
Cannon, H. J. ---------Milwaukee
Cantwell, R. C. ---------Shawano
Carey, H. W. ----------Lancaster
Carl, E. E. ----------Milwaukee
Carlson, G. W. ----------Appleton
Caswell, H. O. ------Ft. Atkinson
Christiansen, James ----Waukesha
Christofferson, A. M. ----Waupaca
Churchill, B. P. -------Milwaukee
Clark, O. C. ---------Oconomowoc
Clarke, T. C. --------Beaver Dam
Clauson, C. T. ----------Bloomer
Cleary, J. H. ----------Kenosha
Coffey, C. J. ----------Milwaukee
Connell, F. G. ----------Oshkosh
Cook, E. F. ----------Milwaukee
Cook, F. S. ----------Eau Claire
Cook, H. E. ----------Milwaukee
Corso, Xavier --------Beaver Dam
Costello, W. H. ------Beaver Dam
Cowan, I. I. ----------Milwaukee
Cowles, R. L. ---------Green Bay
Cox, J. A. ----------Milwaukee
Creswell, C. M. ---------Kenosha
Crosby, E. P. ------Stevens Point

Dallwig, E. L. -------Wauwatosa
Daly, F. P. -------Chippewa Falls
Danforth, Q. H. ---------Oshkosh
Darby, R. C. --------Red Granite
Davis, F. A. ----------Madison
Deicher, H. F. ---------Plymouth
Dennis, J. F. ----------Waterloo
Dettmann, N. F. ------Wauwatosa
Diamond, C. O. -------Milwaukee
Dierker, O. F. --------Watertown
Dietz, R. J. ----------Waterford
Doege, P. F. ----------Marshfield
Doerr, August --------Milwaukee
Domann, W. G. --Menomonee Falls
Donath, L. H. -------Lake Geneva
Donohue, W. E. -------Manitowoc
Dougherty, J. S. ----------Suring
Doyle, T. J. ----------Superior
Drew, F. E. ----------Milwaukee
Drissen, W. H. --Port Washington
Dufour, E. ----------Hayward
Dunker, G. O. ---------Milwaukee
Dvorak, H. J. ---------Milwaukee

Ebert, R. O. ----------Oshkosh
Eck, G. E. ----------Lake Mills
Edmondson, C. C. ------Waukesha
Eisele, P. L. ----------Statesan
Eisenberg, L. A. ------Milwaukee
Ellis, I. G. ----------Madison
Enright, J. A. --------Milwaukee
Epstein, Ely ----------Milwaukee
Erdlitz, F. J. ----------Peshtigo
Ernst, G. R. ----------Milwaukee
Evans, C. A. ----------Milwaukee
Evans, S. M. ----------Milwaukee
Evenson, E. E. -------Wittenberg

Fabric, B. L. ----------Milwaukee
Falk, V. S. ----------Milwaukee
Fechter, F. J. ---------Milwaukee
Fein, N. N. ----------Milwaukee
Feld, S. M. ----------Milwaukee
Feldmayer, J. E. ------Burlington
Fencil, Y. J. ----------Casco
Filek, A. A. ----------Green Bay

Fine, J. M. ----------Cudahy
Fisher, L. M. ----------Milwaukee
Florin, A. C. --------Fond du Lac
Folsom, W. H. ------Fond du Lac
Ford, W. B. ----------Milwaukee
Fortier, C. A. H. ------Milwaukee
Fox, G. W. ----------Milwaukee
Fox, M. J. ----------Milwaukee
Fox, M. S. ----------Milwaukee
Franklin, Emil --------Milwaukee
Frawley, W. J. ----------Appleton
Frechette, F. M. -------Janesville
Freeman, J. M. ----------Wausau
Frick, J. C. ----------Waukesha
Friedbacher, Karl ----West Allis
Friend, L. J. ----------Beloit
Froede, H. E. ----------Jackson

Gantz, H. A. ----------Waukesha
Garding, C. J. ----------Jefferson
Gatterdam, P. C. -------La Crosse
Geiger, S. G. ----------Milwaukee
Gillett, Geo. N. ----------Racine
Gillette, H. E. --------Pardeeville
Gingrass, R. P. --------Milwaukee
Glaubitz, B. J. --------Sheboygan
Glisch, W. P. ----------Milwaukee
Gonce, J. E. ----------Madison
Goodman, J. N. -------Milwaukee
Gorder, A. C. ---------Milwaukee
Gordon, J. S. ----------Milwaukee
Gosin, D. F. ----------Green Bay
Gray, A. W. ----------Milwaukee
Grimm, J. J. ----------Milwaukee
Grob, A. R. F. ---------Milwaukee
Grossmann, E. E. --------Chicago
Gundersen, Gunnar ----La Crosse
Gundersen, S. B. -------La Crosse
Guy, E. F. ----------Milwaukee

Habbe, J. E. ----------Milwaukee
Haessler, F. H. -------Milwaukee
Hagerup, T. A. -------Dodgeville
Hall, R. M. ----------Milwaukee
Hammond, R. W. ------Manitowoc
Hansen, H. J. ----Sheboygan Falls
Hansen, John ---------Glenbeulah
Hardy, C. F. ----------Milwaukee
Hargarten, L. J. ------Milwaukee
Harris, A. J. ----------Adams
Harris, J. W. ----------Madison
Hartman, R. C. --------Janesville
Hatfield, M. E. --------Janesville
Haug, J. F. ----------Milwaukee
Hayman, C. S. ----------Boscobel
Hegner, G. T. ----------Appleton
Heiden, H. ----------Sheboygan
Heinan, F. C. ---------West Allis
Heipp, E. A. ----------Milwaukee
Helmbrecht, M. G. -------Elkhorn
Henske, W. C. ----Chippewa Falls
Heraty, J. A. ----------Milwaukee
Heraty, J. E. ----------La Crosse
Hershberg, R. A. -----Wauwatosa
Hertel, A. J. ----------Milwaukee
Hilker, H. C. ----------Racine
Hill, N. A. ----------Madison
Hirschboeck, J. S. -----Milwaukee
Hitz, J. B. ----------Milwaukee
Hoffmann, G. H. ------West Allis
Hofmeister, F. J. ------Milwaukee
Hogan, J. M. ----------Oshkosh
Holbrook, A. A. --------Milwaukee
Holbrook, A. T. -------Milwaukee
Hollenbeck, S. W. -----Milwaukee
Huber, G. W. ----------Minocqua
Huberty, F. J. ----------Appleton
Hudson, L. A. ---------Milwaukee

Huff, F. C. ---------Sturgeon Bay
Hughes, B. J. --------Winnebago
Hugo, D. G. ----------Oshkosh
Hurlbut, J. A. ----------Madison
Huth, E. P. ----------Belgium
Hutter, A. M. -------Fond du Lac

Ingersoll, B. P. ---------Plainfield
Ingersoll, R. S. ----------Oxford

Jenner, J. A. ----------Milwaukee
Jewell, E. L. ----------Loganville
Jochimsen, M. A. ------Milwaukee
Johnson, E. S. ----------Oregon
Johnson, J. M. ----------Ripon
Juckem, G. J. ---------Sheboygan
Judge, T. A. ----------Milwaukee

Kalb, C. H. ----------Grafton
Karsten, J. H. ----------Horicon
Kasak, Michael ------Wauwatosa
Kauth, C. P. ----------Slinger
Keenan, L. J. -------Fond du Lac
Kelly, J. P. ----------Pewaukee
Kennedy, W. R. -------Milwaukee
Kenney, H. J. ----------Delavan
Kersten, N. M. ----------De Pere
Kidder, E. E. ------Stevens Point
Kief, H. J. ----------St. Cloud
Killins, W. A. ---------Green Bay
Kissinger, C. A. -------Milwaukee
Klein, J. T. ----------Milwaukee
Kleinpell, W. C. --------Kenosha
Kleis, W. J. ----------Milwaukee
Klumb, M. G. ---------Milwaukee
Knauf, F. P. ----------Kiel
Knauf, J. A. ---------Stockbridge
Knox, E. S. ----------Green Bay
Knudson, A. H. -------Milwaukee
Kosanke, F. E. -------Watertown
Krahn, G. W. -------Oconto Falls
Kretchmar, L. H. -----Milwaukee
Krembs, F. R. -----Stevens Point
Kristjanson, H. T. -----Milwaukee
Kritter, F. J. ---------Milwaukee
Krohn, Robt. --Black River Falls
Krumbiegel, E. R. -----Milwaukee
Kuegle, F. H. ----------Janesville
Kurtz, C. M. ----------Madison
Kustermann, A. F. ----Milwaukee

La Croix, G. M. ----------Shiocton
Lahmann, Albert ------Milwaukee
Landis, R. V. ----------Appleton
Lappley, W. F. --------Waukesha
Lee, H. J. ----------Oshkosh
Leicht, Phillip --------Lake Mills
Leitch, G. W. ---------Milwaukee
Leonard, T. A. ----------Madison
Liefert, W. C. --------Milwaukee
Lindsay, W. T. ----------Madison
Lockhart, C. W. ----------Mellen
Lokvam, L. H. ----------Kenosha
Loughlin, D. M. -------Milwaukee
Loughnan, A. J. ----Oconomowoc
Lowe, R. C. ----------Neenah
Ludden, H. D. -----Mineral Point
Ludden, R. H. ----------Viroqua
Lustok, M. J. ---------Milwaukee

Maas, W. C. ----------Rio
MacDonald, W. H. --Lake Geneva
Madison, F. W. --------Milwaukee
Malensek, M. C. -------West Allis
Marquardt, C. R. ------Milwaukee
Marsh, H. E. ----------Madison
Marshall, F. S. ------Black Earth
Marshall, S. B. -------Hollandale
Martens, E. W. -------Milwaukee

Mason, P. B. ----------Sheboygan
Mastalir, L. O. --------Burlington
Mauthe, Walter ------Whitewater
McCabe, John ---------Milwaukee
McCormick, G. L. -----Marshfield
McCormick, T. F. -----Milwaukee
McNamara, L. V. --------Montello
McNaughton, W. T. ----Milwaukee
McNevins, E. S. --------Green Bay
Meanwell, W. E. ---------Madison
Meier, W. G., Jr. ------Sheboygan
Meister, F. O. ----------Madison
Meloy, G. E. ----------Milwaukee
Mensing, E. H. --------Milwaukee
Meyer, O. O. ----------Madison
Midelfart, C. F. ---------Madison
Miller, S. R. -------Stevens Point
Milson, Louis ---------Green Bay
Mishoff, I. D. ----------Milwaukee
Moglowsky, S. --------Milwaukee
Moland, O. G. ----------Augusta
Monsted, J. W. ------New London
Montgomery, R. P. ----Milwaukee
Moon, J. F. ----------Baraboo
Morgan, J. E. ---------Milwaukee
Morgan, S. F. ---------Milwaukee
Moriarty, L. J. -------Two Rivers
Morrison, R. C. -------Winnebago
Morter, R. E. ----------Milwaukee
Morton, H. H. --------Dodgeville
Moss, J. G. ----------Westfield
Muehlhauser, J. O. --Sturgeon Bay
Mueller, J. F. ----------Plymouth
Muenzner, R. J. -------Milwaukee
Mulsow, J. E. ---------Milwaukee
Murphy, F. D. ---------Milwaukee

Nadeau, E. G. ---------Green Bay
Nammacher, T. H. --Oconomowoc
Nauth, D. F. ----------Kiel
Naylen, F. J. ----------Adell
Neff, E. E. ----------Madison
Neilson, G. W. --------Milwaukee
Nelson, W. L. --Wisconsin Rapids
Nesbit, M. E. ----------Madison
Neumann, W. H. ------Sheboygan
Newcomb, C. J. -------Milwaukee
Nimz, R. A. ----------Wauwatosa
Northey, T. M. --------Milwaukee

O'Connor, W. F. ------Ladysmith
Ohlsen, M. P. ----------Monticello
O'Hora, C. M. --------Beaver Dam
O'Leary, T. J. ---------East Troy
Osgood, C. W. -------Wauwatosa
Oswald, Frederick ----Milwaukee
Overton, O. V. ---------Janesville
Owen, G. C. ----------Oshkosh
Ozanne, B. K. ----------Neenah
Ozonoff, J. B. ---------Milwaukee

Pallasch, F. J. ---------Milwaukee
Partridge, C. D. ----------Cudahy
Paulbeck, T. M. -------Milwaukee
Pawsat, E. H. ------Fond du Lac
Pease, W. A. ----------Rio
Pember, A. H. ----------Janesville
Pessin, Joseph ----------Madison
Peters, L. M. ----------Milwaukee
Peterson, M. G. --------Lake Mills
Peterson, R. O. ----------Racine
Peyton, L. T. ----------Milwaukee
Pirsch, Margaret V. -----Kenosha
Pitz, M. N. ----------Neenah
Pohle, E. A. ----------Madison
Poser, John F. ---------Columbus

Presti, A. A. ----------Milwaukee
Purdy, F. P. ---------Mukwonago
Prudowsky, H. H. -----Milwaukee

Quick, A. J. ----------Milwaukee
Quigley, L. D. ---------Green Bay

Radloff, A. C. ----------Plymouth
Rastetter, J. W. ------Milwaukee
Rauch, W. A. ---------Manitowoc
Rawlins, J. A. ----------Elkhorn
Raymond, R. G. ------Brownsville
Regan, J. R. ---------Wauwatosa
Reifenrath, I. B. ------Milwaukee
Rice, E. M. ----------Milwaukee
Robb, J. J. ----------Green Bay
Roberts, D. W. -------Milwaukee
Roberts, H. M. -------Wauwatosa
Robinson, A. H. --------Jefferson
Rogers, Malcolm F. ----Milwaukee

Salan, Sam ----------Waupaca
Sanfelippo, A. J. ------Milwaukee
Sarfatty, I. J. ---------West Allis
Sargeant, H. W. ------Wauwatosa
Schaefer, C. O. ----------Racine
Schenkenberg, Grace E. ---Racine
Schilling, H. J. ---------Denmark
Schindler, J. A. ----------Monroe
Schlomovitz, H. H. --------Barron
Schlueter, U. A. -------Milwaukee
Schmidt, E. R. ----------Madison
Schneeberger, L. J. ----Milwaukee
Schneider, C. R. ------Milwaukee
Scholter, E. A. W. ----Milwaukee
Scholz, H. F. ---------Thiensville
Schubert, C. K. ----------Madison
Schultz, Isadore ------Mazomanie
Schwade, Edward -----Milwaukee
Seelman, A. G. --------Milwaukee
Seevers, M. H. ----------Madison
Selle, F. S. ----------Milwaukee
Seward, L. J. ----------Berlin
Shabart, E. J. --------Milwaukee
Shaiken, Joseph -------Milwaukee
Shapiro, H. H. ----------Madison
Sharpe, H. R. -------Fond du Lac
Shearer, H. A. ----------Beloit
Shutter, H. W. --------Milwaukee
Simon, L. J. --------Fond du Lac
Simonson, L. M. -------Sheboygan
Sinaiko, E. S. ----------Markesan
Sokow, Theodore --------Kenosha
Somers, A. J. -----Chippewa Falls
Spilberg, S. ----------Milwaukee
Sprague, J. T. ----------Madison
Springer, V. G. ----------Omro
Stebbins, G. G. ----------Madison
Stein, C. C. -----Port Washington
Steinkopff, E. K. ------Milwaukee
Steves, R. J. ----------Menomonie
Stewart, W. C. ----------Kenosha
Stockinger, R. E. -----Milwaukee
Stratton, F. A. --------Milwaukee
Strong, R. G. ---------Manitowoc
Stubenvoll, C. E. -------Shawano
Stueck, A. F. ---------Manitowoc
Sumner, W. C. ----------Edgerton
Sure, J. H. ----------Milwaukee

Tasche, John ----------Sheboygan
Taube, E. L. ----------Milwaukee
Taylor, J. G. ----------Milwaukee
Teitgen, T. A. --------Manitowoc
Tenney, H. K. ----------Madison
Terlinden, J. H. ---------Bonduel
Tharinger, E. L. ------Milwaukee
Thomas, G. L. ---------Janesville
Thompson, R. D. ------Milwaukee
Thornton, M. J. ----------Madison
Thorstensen, A. H. ----Milwaukee
Tierney, E. F. ----------Portage
Tormey, T. W. ----------Madison
Tormey, T. W., Jr. ------Madison
Torpy, T. G. ----------Minocqua
Towne, W. H. --------Hortonville
Trautmann, M. ----------Madison
Troup, W. J. ----------Green Bay
Trumbo, J. K. ----------Wausau

Van Hecke, L. J. ------Milwaukee
Van Riper, H. E. --------Madison
Van Schaick, R. E. --------Marion
Vander Linde, L. A. ----Milwaukee
Venning, J. R. ----Fort Atkinson
Vieaux, J. W. ---------Green Bay

Waffle, R. L. --------Fond du Lac
Wagner, A. J. ----------Brillion
Wagner, R. F. ----------Oshkosh
Waldeck, E. A. -------Milwaukee
Waldkirch, R. M. --------Wayside
Walker, L. J. ---------Milwaukee
Wall, C. E. ----------Manitowoc
Walters, D. N. ------Fond du Lac
Warner, R. C. --------Milwaukee
Waters, R. M. ----------Madison
Wegmann, G. H. ------Milwaukee
Wendt, F. A. ------Johnson Creek
Werner, D. J. ---------Milwaukee
Weston, F. L. ----------Madison
Wheeler, R. M. ----------Madison
Wier, F. A. ----------Racine
Wiesender, A. J. ----------Berlin
Wilets, J. B. ----------Milwaukee
Wilkinson, E. D. ------Milwaukee
Wilkinson, J. D. ----Oconomowoc
Williamson, C. S. -----Green Bay
Wilson, N. M. ---------Reedsville
Wilson, O. M. ----------Wausau
Winn, H. N. ----------Madison
Wirka, H. W. ----------Madison
Wirthwein, Carlton ---Milwaukee
Wisiol, Erich ------Stevens Point
Wiswell, C. Y. -----Williams Bay
Witcpalek, E. W. ------Kewaunee
Witcpalek, W. W. ---------Algoma
Witte, W. C. F. -------Milwaukee
Wochos, F. J. ---------Kewaunee
Wood, C. A. ----------Waukesha

Yaffe, Aaron ----------Milwaukee

Zaegel, R. L. ----------Sheboygan
Zboralske, F. F. ------Fall Creek
Zietlow, F. G. ---------Waukesha
Zimmermann, C. ------Milwaukee
Zimmermann, F. H. --Watertown

Friday, September 20

Alvarez, R. L. ----------Galesville
Atkinson, H. S. -------Green Bay

Bachhuber, F. G. --------Mayville
Bargholtz, W. E. ------Reeseville
Barr, A. H. -----Port Washington
Baugh, C. W. ---------Milwaukee
Bayley, W. E. ---------La Crosse
Bennett, J. F. ---------Burlington
Bleckwenn, W. J. -------Madison
Borsack, K. K. ------Fond du Lac
Buckley, C. H. -------Menomonie
Buerki, R. C. ----------Madison
Dessloch, E. M. --Prairie du Chien
Dishmaker, M. C. ------Milwaukee

Edelman, Elsa R. B. --Milwaukee

Gloss, A. J. ----------Appleton

Hannan, K. D. L. --Prairie du Sac
Hansen, J. W. --------Milwaukee
Harrington, E. T. -----Milwaukee
Herner, W. L. --------Milwaukee
Hittner, V. J. ----------Seymour
Hitz, H. B. ----------Milwaukee
Huber, H. H. ---------Milwaukee
Hull, H. H. ----------Brandon

Jeffers, Dean -------Lake Geneva
Jordan, E. M. ---------Green Bay
Jorgenson, H. L. -------Marinette
Juster, E. M. ----------Madison

Kauth, P. M. ---------West Bend
Kay, E. M. ----------Milwaukee
Kennedy, H. A. ------Winneconne
Kern, T. J. ----------Richfield
Kinsey, J. L. ----------Milwaukee
Knauf, N. J. ----------Chilton

Lorenz, W. F. ----------Madison
Loughlin, T. F. ---------Hartford

MacGregor, J. W. --------Portage
Markson, L. S. --------Milwaukee
Markson, S. M. --------Milwaukee
McCarty, R. T. ---------Appleton
McDonough, K. B. -------Madison
Miller, R. H. ---------Whitewater
Muenzner, R. J., Jr. ----Milwaukee

O'Brien, Paul T. --------Menasha

Pauly, L. F. ----------Sheboygan
Pearson, C. R. ----------Baraboo
Perssion, L. B. --------Winnebago
Pessin, S. B. ----------Madison
Peterson, L. W. --------Shawano
Pfefferkorn, E. B. -------Oshkosh
Pomainville, G. J. --------Nekoosa
Pomeroy, R. K. --Port Washington

Quick, E. W. ---------Milwaukee

Randolph, T. G. -------Milwaukee
Rankin, F. J. ----------Appleton
Rheineck, A. F. ------Milwaukee
Rodgers, R. S. ----Chippewa Falls
Rogers, A. F. ---------Milwaukee
Ruehlman, D. D. ---------Monroe

Schubert, F. J. --------Milwaukee
Schwartz, A. B. -------Milwaukee
Seeger, S. J. ----------Milwaukee
Spooner, A. D. --------Milwaukee
Stebbins, W. W. ---------Madison
Strand, R. C. ---------Eau Claire
Swartz, K. A. ----------Waupun
Sweet, S. J. ----------Milwaukee
Szymarek, J. E. -------Milwaukee

Theobald, P. B. -----Oconomowoc

Usow, J. M. ----------Milwaukee

Waldschmidt, W. J. --Fond du Lac
Welke, E. G. ----------Madison
Winter, E. F. ----------Strum

The Physician in Selective Service*

By COL. W. F. LORENZ
Chief Surgeon, Wisconsin National Guard, Madison

THE medical profession contributes a very essential part to the operation of Selective Service. Perhaps the physician's responsibilities will be better comprehended if the fundamentals of Selective Service are briefly mentioned.

The process starts with a proclamation by the President of the United States. This has been done. October 16 has been set at which time all males of certain age groups must register. This is to be completed on one day and is designed merely to list the names, addresses, and next of kin of all those who are required to register. No male person within the age groups specified is exempted from the duty of registering.

Immediately after registration, the Local Boards for Selective Service are organized. These Boards are distributed throughout the nation and on the basis of one Board to about 30,000 of population. There will be approximately 6,000 such Boards in the United States and 130 in the State of Wisconsin. This local Board consists of three men who are named by the Governor but appointed by the President of the United States. After taking the oath, they are officials of the United States Government and responsible to it for their subsequent duties.

Local Board Medical Examiner

The Local Board has final decision in every matter dealing with the selection of men for our national defense. The physician or medical examiner to the Local Board is not a member of the Board. He has no vote in its decisions. He is required to make physical examinations and report his findings to the Board, but his decision as to the physical fitness of the registrant is not final. The Local Board may accept or reject his conclusions. This relationship between the medical examiner and the Local Board must be understood not only by the physician but also by the Local Board, the public, and the person as well.

The medical examiner assigned to a Local Board is named by the Governor and appointed by the President. His remuneration is the same as that allowed to members of the Local Board. This is fixed at $1 per hour, and not to exceed $10 per day.* The actual number of hours devoted to physical examinations must be recorded in the minutes of the Local Board in order that the physician may be compensated.

Immediately after registration day, the Local Board begins its very important job of classifying the registrants. A questionnaire designed to bring out the necessary information for classification is sent to each person registered and residing in the district over which the Local Board has jurisdiction. As these questionnaires are returned, the Board analyzes each questionnaire, and proceeds to place the persons into one of four classes.

Those who are not employed in certain fields that are specified in the regulations, and those who have no dependents and are not specifically exempted by law, are placed in Class I, unless the Board finds the registrant to be physically or mentally totally unfitted for military service, in which event he is placed in the most deferred group, that is, Class IV.

All registrants who are employed in certain fields that are regarded as essential industries, which includes agriculture, and those holding elective office in federal, state, or municipal service, as well as some other forms of employment that are named in the regulations, comprise Class II.

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* Presented before the 99th anniversary meeting, State Medical Society of Wisconsin, Milwaukee, September 20, 1940.

* *Editor's note.*—Late press reports seemingly indicate a possibility that medical examiners for Local Boards may be asked by the government to serve as a patriotic duty and without compensation.

All registrants who have persons dependent upon them such as minor children, helpless or crippled adult relatives, and other forms of dependency that are specified in the regulations, fall into Class III.

Class IV is the most deferred group. In this class will be placed registrants who are found to be totally and permanently disabled, also certain officials of the government and state and other fields that are exempted from military service by law, such as clergymen. Enemy aliens are placed in Class IV, also criminals and others that are regarded as morally unfitted for military service. The regulations clearly specify those who must be placed in Class IV.

In the above description, I have merely cited some of the conditions that determine a registrant's classification, and those cited merely illustrate the general nature of the conditions which place a person in Class I, II, III, or IV.

Up to this time, the physician has had no responsibility. For example, the Board, of its own accord, may, upon information or its own observation, find a registrant to be physically or mentally disqualified from service. If such a decision is arrived at by unanimous vote, the registrant is grouped in Class IV.

The Physical Examinations

After the Board has classified the registrants, all those grouped in Class I are recalled for a physical examination. This is the time when the medical examiner assigned to the Board begins to function.

The medical examiner can require the Local Board to provide adequate facilities for a thorough physical and mental examination. If necessary, he can be supplied with professional or lay assistants. He has the authority to make whatever examination he believes to be necessary, and after he has made such an examination, he reports his findings to the Local Board.

The report by the medical examiner is made on a very simple form, but he is required to make a positive finding. He must state definitely that a person is either physically fit or unfit for military service, and by military service is meant duty with the army, navy or marine corps. If he finds some to be partially handicapped and not coming up to the minimum standard for unlimited duty in any branch of the military service, he may recommend such a person for a limited form of military service.

His finding, therefore, must be a recommendation that a person is fit for unlimited military service, fit for a limited form of military service, or unfit for any form of military duty. However, the final decision even in the sub-classification of Class I rests with the Local Board, and such decision to be final must always be unanimous.

Those who are found by the Local Board to be fit for any form of military service are designated as Class I–A. Those found by the Board to be somewhat handicapped and capable of only a limited form of military service but still usable in some manner for national defense are grouped as Class I–B.

The Selective Service process has now reached the stage where there is a group of registrants classified as Class I with the further sub-classification of A and B. The designation of A and B is made after the physical examination.

The authority of the medical examiner is obviously limited. This must be fully appreciated. One's immediate reaction to this is perhaps astonishment that three laymen should be authorized to decide a purely medical problem. But much can be said in favor of this plan. It seems to me that it merely carries out the fundamental idea of the Selective Service process. It must be understood that the whole operation of Selective Service is a civilian effort and particularly designed as a local responsibility. A group of three responsible, intelligent men of unimpeachable integrity are chosen to select conscientiously persons for compulsory military service in accord with their best judgment, holding in mind, of course, national defense, but also holding in mind our national economic and social welfare, and the particular problem presented by the person who is being considered. The whole plan contemplates weighing every person in a certain balance, and it is believed that a Local Board of the character mentioned is

in the best position to be well informed and deal justly. The medical examiner then is like the family physician. His service and help are sought. It is almost always accepted and acted upon, but it may be rejected. That is a privilege which any patient or family can exercise, and that seems to be the privilege vested in the Local Board. The degree to which the Local Board has authority in purely medical matters is then consistent with the usual professional relationship that obtains between any family and its physician.

However, there are definite provisions in the regulations that are presumably designed to prevent any abuse of authority that is vested in the Local Board. For example, any registrant who is placed in Class IV as physically or mentally totally unsatisfactory for military service, can be so classified only by a unanimous vote, and incidentally such a vote must be recorded in the minutes of the Board. If the vote that classifies a registrant on physical grounds is not unanimous, the case is then automatically referred to a Medical Advisory group. If the medical examiner differs in his opinion from the decision of the Board, he can require the case to be referred to the Medical Advisory Board. If the Government Appeal Agent, who is present with a Local Board and is charged with protecting the interest of the Government and the person as well, is not satisfied, he can require a case to be referred to the Medical Advisory Board. And so there is a system of checks present in the operation of Selective Service that should insure absolute equity in its operation. Mention might also be made that an Appeal Board superior to the Local Board is available to either side in any controversy that may arise.

Eighteen Medical Advisory Boards

The Selective Service plan provides for Medical Advisory Boards. These are specified as groups of specialists including an internist, a surgeon, an orthopedist, a genitourinary specialist, a neuropsychiatrist, and a dentist. Such members of Medical Advisory Boards are also named by the Governor and appointed by the President. However, they receive no compensation for their service. Medical Advisory Boards are to be conveniently located throughout the state. The Adjutant General has planned for eighteen such Boards.* In most instances, such Boards will be closely connected with some large hospital where all facilities for a more detailed examination are available. The decision of such a Board or any member thereof is reported to the Local Board, but again, as in the instance of local medical examiners, the Board may accept or reject such a recommendation, and if a unanimous decision is not reached, the case then goes to the Board of Appeals for a decision.

I had no personal experience with the draft in 1917–1918, but after my recent attendance at a Selective Service school, I became interested in the whole procedure and particularly the purely medical problems that confront the physician.

The Second Report under the date of December 20, 1918 by the Provost Marshal General contains much information that can be used to advantage in the problem that confronts us. From this report I have selected some purely medical data that reflect the experience of examining physicians at that time, and may perhaps be used as a guide to us in the job that will confront at least 200-odd physicians of Wisconsin within the near future. It seems to me that the medical problems are no different today from what they were twenty-five years ago. The human has not changed as a biological organism, even though the technic of war has changed most profoundly. In short, the conditions that were found at that time in the mass of men examined will very likely be found again in those about to be examined.

Anticipated Types of Disabilities

I will mention only the most frequent forms of physical disability that accounted for rejections by the Local Boards and subsequently by the mobilization camp surgeons.

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* Located as follows: 4 in Milwaukee. 1 in each of the following cities: Racine, Janesville, Madison, La Crosse, Eau Claire, Chippewa Falls, Wausau, Ashland, Superior, Rhinelander, Green Bay, Appleton, Oshkosh and Fond du Lac.

The following data are from rejections throughout the United States. The complete information concerning the variety of defects that were found to be disqualifying for military service is contained in Table 60 of the Second Report of the Provost Marshal General. The total number rejected for all causes between February 10, 1918 and October 15, 1918 was 467,694.

Types of Disqualifying Defects Found in 467,694 Persons Rejected by Local Boards and Camp Surgeons During the Period From February 10, 1918 to October 15, 1918

	Number	Percentage
Total for all causes	467,694	100
Heart and blood vessels	61,142	13
Bones and joints	57,744	12
Eyes	49,801	11
Mental and nervous disorders	48,242	10
Respiratory tuberculosis	40,533	9
Tuberculosis of parts other than respiratory	4,136	1
Height, weight, chest measurements, etc.	39,166	8
Hernia	28,268	6
Ears	20,465	4
Teeth	14,793	4
Flatfoot (pathological)	18,087	4
Skin	12,519	3
*Thyroid	8,215	2
Respiratory (non-tuberculous)	7,823	2
Genitourinary (venereal)	6,235	1
Genitourinary (non-venereal)	6,309	1
Alcohol; drug; digestive system and all others	18,797	4
Cause not given	25,419	5

* Note that in Wisconsin the rejections for thyroid dysfunction were 6.1 per cent. The only higher incidence was 6.2 per cent found in Washington, D. C.
The above data are taken from Table 60, Second Report of the Provost Marshal General, 1918. Fractional percentage is ignored.

The work of the local examiner is subject to an evaluation because after induction, the registrant is again physically examined at the mobilization camp. It is interesting to note that the camp surgeon's findings were remarkably similar to those of the local medical examiner. Of course, there was no method of checking upon the registrants who were rejected by the Local Boards. Upon the other hand, the check upon those who were accepted as physically fit shows a 92 per cent agreement between the camp surgeons and the examining physicians of the Local Boards. That is, about 8 per cent of the registrants accepted as physically fit by Local Boards were subsequently rejected by the camp surgeons. I am inclined to believe that 92 per cent of agreement between medical men is quite remarkable. However, one must hold in mind that this is an agreement on essentially normal findings.

It is interesting to note that the physical defects found at the time of the original examination occur with practically the same relative frequency in those persons who were rejected by the camp surgeons after acceptance by the Local Boards. In short, not only are these forms of physical impairment most frequent but they appear also to be the most difficult to recognize. This is further borne out by the fact that after acceptance by the Local Board and the camp surgeon as well, and after brief duty with the military forces, one finds practically the same frequency in causes for discharge from the army. An exception, however, is noted in the instance of mental and nervous disorders, which will be mentioned later. But, excepting these, the causes for discharge after the person served for a short time show—

	Per cent
Heart and blood vessels	13
Bones and joints	12
Respiratory tuberculosis	5
Ears	5
Eyes	4
Hernia	3
Thyroid	3

All of this should serve to direct the examination particularly toward these most frequent forms of physical impairment.

There is another interesting experience of the World War draft that might be mentioned briefly, although I regret I have no suggestion to make as to what can be done to improve the method of examination and prevent thereby the induction of this group of persons into the army. It seems that large numbers of men were discharged from military service after a month, or less, of actual duty. Of these, 23 per cent were diagnosed as having mental deficiencies or mental disease. It seems evident that the necessarily hurried and practical examination made by the local examiner and the camp surgeon as well does not disclose some of these mental cases. In fact, this is not unlike our daily experience. Some forms of mental

impairment become evident only after an observation of behavior over a period of time. A month or more of actual duty brings out such mental defects. However, this experience in the World War suggests at least the need of focusing considerable inquiry into the history of the individual by the local examiner. He is in a better position to get reliable information than the camp surgeon. If he can discover these cases at an earlier date and prevent such a handicapped person from being inducted into the military service, much good will be accomplished.

Routine Blood Tests

I have one suggestion to make concerning a part of the physical examination by the local physician. The regulations do not require it, but I could find nothing that would prevent its being done, if the local physician chooses to do so. I refer to an effort to discover syphilis in the recruit and prior to the period of induction. I believe we have ample facilities in Wisconsin to make a routine blood test upon each registrant who is physically examined. I would, furthermore, suggest that if a test is found positive, the case should be referred to the Medical Advisory Board. The examination by the Medical Advisory Board should focus especially upon the central nervous and cardiovascular systems. If no involvement is found to exist, and the registrant is noninfectious, he should be returned to the Local Board with the recommendation that he be accepted for military service, but the record of the physical examination should clearly carry a notation to the effect that the blood was positive.

From the very beginning, the medical profession has always rendered an effective, conscientious, and unselfish service to our country when at war. That is our past record, and I am certain it will be our future record as well. No physician undertaking the responsibility of medical examiner to the Local Board will do so because of the compensation involved. It must, therefore, be recognized as a special duty and an act of patriotism on the part of the medical profession.

Pre-Employment Physical Examinations*

By MR. HARRY A. NELSON

Director, Workmen's Compensation Department, Wisconsin Industrial Commission, Madison

CERTAIN divergences of position indicate that misunderstanding and controversy exist on the part of at least some persons concerning the desirability of physical examinations of employes as a prerequisite to employment or to continuance in employment.

Before the passage of workmen's compensation acts a considerable movement had gained impetus by legislation and initiative on the part of employers to reduce the number of injuries caused by industrial hazards. When compensation acts required employers to answer in benefits to every employe who sustained industrial injury, there was a decided quickening of pace working toward prevention of injuries and consequent savings in cost.

The Wisconsin statute requires that employers shall furnish employment and places of employment which shall be safe for employes, shall furnish and use safety devices and safeguards, shall adopt and use methods and processes reasonably adequate to render employment and places of employment safe, and shall do "every other thing necessary to protect the life, health, safety and welfare" of employes. The law not only imposes these duties on employers, but is remarkable for its imposition of a like and reciprocal duty upon employes.

Different interpretations have been given to safety statutes by the courts. They have been construed variously in a narrow and in a liberal manner from the standpoint of

* Presented at the 99th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1940.

employes. Those courts which gave liberal interpretations for protection of workers held that not only was the physical equipment of the plant required to be maintained in a safe condition, but also the workers themselves were to be so chosen, trained, supervised and warned of hazards as to constitute the entire working environment safe in all respects. They have held that as a minimum employes have a right to know what the hazards are to which they are to be subjected—the right to know the ultimate effect of these hazards—the right to choose whether or not to undergo them—the right to know whether a particular employe can withstand these hazards in view of his own physical makeup.

When analysis is made of statistical data covering accidents, it is observed that most of them occur, not because of a failure to guard, not because of hazards of machinery with which employes work, and not because of the physical equipment utilized by the industrial unit; but rather because of failure of the human factor. It is said that from 75 to 90 per cent of accidents occur on account of that failure.

Aside from the abnormalities which involve safety in the doing of work, the employe may be unsafe to others who come in contact with him because he has a disease which may be transmitted.

In industrial medicine the greatest emphasis today is upon the subject of prevention—and properly so. From the days of Koch and Pasteur some of the most glorious achievements of medicine have been those of medical scientists, who, by research, study and practice have been able to learn and prevent the cause of disease.

So in industry the wise approach to the safety of workmen is by prevention of the cause of injury rather than by curing the result of the injury after it has occurred. Is there anything more obvious than the fact that occupational diseases can never be wholly controlled without the use of physical examinations?

Labor organizations have, from time to time, raised their voices against examinations. The protests of labor have not been without foundation. In times past some employers have made invidious use of results of physical examinations to exclude employes with slight physical defects from positions which they might well fill with due safety to themselves and to others. They have used the results of examinations in an attempt to defeat honest claims for workmen's compensation by muddying the water to such extent that the fact of injury has been wrongfully thrown into the field of conjecture. They have dishonestly used findings as a stated reason for separating persons from work. They have failed to study selection and placement in light of physical disability, and thus have relegated admirable human material to the scrap pile in a deplorably wasteful manner. Insurance carriers with myopic activity have, by use of specious propaganda and other methods, induced employers to discharge employes who, although perhaps constituting hazards in some operations of industry, nevertheless are essentially safe and placeable in others. Physicians have lent themselves to the whims and fatuities of employers and insurance companies instead of exercising that care and scrupulous humanity and honesty which the medical profession should always observe. Some physicians have not had sufficient knowledge of job requirements, nor have they considered defects from a point of view of man, job and employer. They have not recognized that many defectives can be employed with safety and without handicap or lack of efficiency. So, any program of a governmental agency which sponsors medical examinations must first of all provide safeguards for their scope and use so that neither employes nor employers may be prejudiced by the practice.

Happily but very few employers, insurance carriers, or physicians have been so unenlightened and shortsighted as to carry out these types of practice. The vast majority, and increasingly so, has exhibited sympathy and beneficence, if not always intelligence, toward employes, sometimes even to the point of doing them actual harm by placing them in positions where they should not be.

There have been written into the Wisconsin law several provisions intended to discourage oppressive plans of physical examination and rejection of employes or applicants for employment. It is provided that the advantage of experience rating, and consequent lower rate of premium for compensation insurance, shall be forfeited by the employer who applies an oppressive plan of examination. Many employers, because of experience rating, may have their premiums reduced as much as 40 per cent, so loss of the benefit of experience rating is a serious item to them. Self-insurers are deterred from operating such plans by a provision granting the Industrial Commission power to revoke the exemption from insurance of the employer who institutes them. Insurance carriers may have their licenses to operate in Wisconsin revoked if they "encourage, persuade or attempt to influence any employer arbitrarily or unreasonably to refuse employment to or to discharge employes."

From the humanitarian and economic standpoints, there seems to be good reason why physical examinations should be generally instituted in industry. Our shibboleth should be: *Place every worker who is fit for work, and displace only those whose condition spells danger.*

The Wisconsin Program

More than two years ago the Wisconsin commission called a conference of interested parties, including representatives of labor organizations, employers, physicians and insurance companies, to consider the possibility of setting up a program of physical examination of employes. As a result of subsequent deliberations, the main committee presented a report, following which the Industrial Commission adopted the "Wisconsin Physical Examination Program."

The statement of the commission is that all physical examinations are to be made by physicians selected by the employer. If there is a grievance on the part of the examined employe, the Industrial Commission, on proper complaint, will cause investigation to be made, and if the grievance is found to be justified, the employer is to cause further examination of such employe to be made by another physician. The report urges that any practice inconsistent with the plan be presented to and acted upon by the Industrial Commission. For such purpose the commission may appoint an advisory committee to be composed of representatives of labor, industry, and of the medical profession. Examinations are to be paid for in full by the employer, and any lost time or transportation expense occasioned by examinations to employes in service is likewise to be assumed by the employer. It is provided that initial examinations of new employes should be made prior to employment if possible. It is recognized, however, that in case of short temporary periods of employment, examinations are not always feasible, and that in other cases there may be uncertainty as to qualifications other than physical fitness, so a test period is provided to enable the employer to learn of the employe's qualifications and to delay pre-employment examination in such cases for a period not in excess of thirty days. It is also recognized that the term for re-examination will vary with different classes of employes, and for different types of work.

With these principles in mind, the committee adopted a report covering scope of examinations, re-examinations and specified procedures for different types of employment. Forms for reporting of physical examination were adopted.* In addition to physical examination, laboratory procedures are to include a chest x-ray film (flat plate), serologic blood test for the diagnosis of syphilis, urinalysis for sugar and albumin determination only, and blood examination. The forms cover occupational history, present complaints, weight, vision, hearing, teeth, throat, heart (rate and abnormal findings), blood pressure, chest and lungs, abdomen, back, hernia, skin, extremities, reflexes, varicose veins, glands, temperature, sputum (only when indicated), blood count and sedimentation rate (only when indicated). Special examinations are to be made where indicated in specific industries.

One of the remaining scourges still prevalent in our civilization is that of tuber-

* See notice in box in accompanying columns.

culosis. What would one say of an employer who would deliberately place a person with an active case of tuberculosis at work involving close contact with dozens of other employes? Is it not equally indefensible to fail to discover those active cases of tuberculosis which may be found in numbers of employes, and which can be discovered by examination? True it is that the sort of examination which an employer is able to give and can afford to give will not detect all of the cases of tuberculosis. It will, however, detect the openly active case from which the greatest danger may be anticipated. Recently much has been done toward eradication of syphilis. The federal government has initiated a concerted drive on all lines for eradication of this disease. In Wisconsin the state makes the test for syphilis without cost to the patient or his physician.

The committee believes that in a noninfectious stage, syphilis should not exclude an individual from pursuing his trade, but should certainly call for medical control.

Obviously, in industries which present excessive hazards, or where it is necessary to examine an individual to learn whether the hazard to which he is exposed has affected or may affect him, rather frequent examination will be required. In the case of beginning silicosis, where the possibility of involved tuberculosis may be present, examinations need to be conducted at shorter intervals. Where the lung may be affected, x-ray examinations are always necessary.

The subcommittee debated whether or not the report should be supplied in its original form and to both employe and employer. It was recommended that the detailed original examination form be retained by the examining physician for his own record, and that no other similar form be issued to either employe or employer. However, the employer and the employe are to be informed of any defects which are found which may affect the safety of the worker or his fellows in their work, so that the purpose of the program will be carried out as to correction of defects if necessary, and as to placement in positions where the defects may not prove detrimental. The employer wishes only to know whether the employe is physically able to work at certain jobs. If he is adjudged physically unfit, the employer has a right to know the reason. If defects can be corrected, the employer and the employe have a right to know that, so that the worker may, if possible, be afforded work after the defect has been remedied. So the report which is given to the employer and employe contains a brief notation as to physical defects (other than lungs), visual defects, and when pertinent, a further notation as to lung examination, with suggestions and recommendations.

FORMS FOR REPORTING EXAMINATIONS

The State Medical Society of Wisconsin will furnish to members, at cost of publication, pads of the model examination and report-of-findings forms referred to in this article and displayed at the recent annual meeting of the Society in Milwaukee.

A set of forms includes 100 examination blanks and 100 report-of-findings blanks (these are in triplicate,—one copy for the employer, one copy for employe, and one for the physician's file).

Cost:

(1) **Printed with your name and address** _____ **$4.75**

If you order blanks with your name and address, be certain to type this information just as you wish it to appear on the blanks.

(2) **Printed without your name or address** _____ **$3.00**

Address all orders to:

Miss Dorothy Cridland,
State Medical Society of Wisconsin,
917 Tenney Building,
Madison, Wisconsin.

Physician-Employe Relationship

Always it is to be stressed that the employe is to be considered a personal patient and treated as such by the examining physician. The relationship between these parties is that quasi-sacred relationship which should always exist between physician and patient.

Parenthetically, may I interject a few comments on a matter of mutual concern to physicians and the Industrial Commission?

From time to time we have complaints that some physicians who treat employes subject to the workmen's compensation act regard themselves as owing a duty to employers and insurance carriers superior to that owing to the employes whom they treat. It is stated that some doctors feel that because the employer or insurance company is charged with the cost of treatment the physician becomes the physician of the employer or insurance company. The fact is that the physician who treats at the request of the employer or carrier is, to all intents and purposes, the employe's private physician. He owes to the employer no direct duty except as he owes to his patient the duty of giving competent treatment at a reasonable cost and to call for consultation, when desirable and when requested, or for assistance of specialists when necessary, as he would in a purely private case. In behalf of the employe he owes to the insurance carrier the duty of making prompt and honest reports on a factual basis so that the employe may receive compensation due promptly and on the proper legal basis. The law provides that if the employer or carrier requests opportunity for examination by another physician, that is their right. Beyond this, the physician's sole duty is to the employe in every respect as if the employe had called the physician and assumed payment of the bill himself. Employes sometimes state that attending physicians refuse to give them information or to discuss their cases with them, but refer them to the insurance carrier or employer. That sort of conduct is contrary to the spirit of the compensation law and to good medical ethics. All doubt and criticism can be avoided by the physician definitely taking the only tenable position that can be taken—*that he is the employe's physician throughout* and *that if he treats the employe as such his incidental duty to the carrier will also have been discharged when proper reports have been made to the carrier.*

Much the same practice should apply when a physician examines employes as to their physical qualifications for work. The physician's object should be to place every employe who is able to work at work suitable and available for him. His duty to the employer will be served when he has done this and has ruled out only those employes who are not safe to themselves or to others in any one of the types of work which the employer may have available.

Problems in Evaluating Fitness For Employment

The question of what conditions should influence employment, or continuation in employment after examinations are made, is attended with some difficulty. Largely the clinical judgment of the physician must control, for with him rests the decision of evaluating the physical fitness of an individual. If we follow arbitrary standards too closely we are likely to reject many competent workers who could be placed with benefit to them and to the employer. We must, however, understand the requirements of the job and the limitations of the individual. Many large employers who have successfully instituted examination plans report that rejections are few.

Certain conditions, however, should always disqualify the employe from work, such as active tuberculosis and syphilis in infectious stages, until proof of proper treatment is submitted. High blood pressure should exclude from employment only when associated with damaged heart or kidney function, or both, and then only for strenuous work at particular jobs where the safety of a number of persons depends upon good physical coordination of a few. Serious defects of vision or hearing should exclude from employment in any hazardous physical employment, or where the safety of others depends upon the possession of these faculties.

Necessarily the medical examiner will have to become expert to a degree as to processes and jobs in order that the results of physical examination can be used to the best advantage and without detriment to employer or employe. The cost of examinations will have to be made sufficiently reasonable so that it will not be prohibitive to employers. The principle of volume must be recognized. Life insurance examinations are given at reasonable cost, and yet act to pro-

tect reasonably millions of dollars of reserves. Employers will need to be educated to the understanding that the economic good which will result to the employer will richly repay the cost of examinations.

The Program's Future

The program which has been adopted is far from perfect. It is open to modification and amplification as often and as much as required. So far as is known, this is the first venture of this nature presented by a public agency. The commission hopes that through engineering control and the medical control outlined in the plan, Wisconsin may achieve first rank nationally in occupational disease prevention and control, as it has in its industrial accident prevention program. With the modifications which experience may suggest, the plan should result in increased prevention of accidents and disease, in a happier placement of employes in work, and in greater social and economic good of employer, employe and the state.

Your Records, Doctor!*

By LAWRENCE L. GROSSMANN, M. D.
Milwaukee

WHETHER specialist or general practitioner, any physician may at some time find himself faced with the accident case in which insurance is involved. It may be nothing spectacular—a mild back strain or a few bruises on wrist or ankle from a minor automobile accident. The patient is treated for a short while and then dismissed from further medical care, and, like as not, from the doctor's memory as well. And then, months or years later, when perhaps every single detail has been comfortably forgotten, notice comes that the case is going to court and the physician's testimony is required.

The doctor turns to his records, and in many cases finds them woefully inadequate, as anyone who has examined records and reports in the field of industrial or traumatic surgery will agree. From the point of view of the courts, this is hard to understand. The members of an educated, respected profession can naturally be expected to produce more adequate reports than a first year medical student could write.

The reason is as obvious as the cure. The doctor has simply never developed a good record system, and then allowed habit, the most dependable of all workmen, to take his histories for him. Perhaps he has thought the taking of detailed case histories would only waste the time of the average general practitioner. He doesn't have one case in ten years that has any legal aftermath, and in that one, with its possible attendant embarrassment on the witness stand, he is willing to trust memory for details.

In a case of this type the doctor does have a definite responsibility. He owes the insurance carrier a prompt and complete descriptive report of his first examination of the patient. Nor does responsibility stop there. Inasmuch as it is the insurance company that pays the bills, it is only good business to keep the company informed of all the salient facts. So that the physician's bill will not seem out of line when presented at the time the patient is dismissed, the doctor is wise to submit additional reports at least once a week, describing the progress of the case and the treatment rendered since the last report.

It should hardly be necessary to add that the physician must keep in his own personal files an exact carbon copy duplicate of every report that leaves his office. For that case may come to court and the doctor's testimony be required. It is a distressingly common sight in our court rooms to see physicians render testimony, which may be anywhere from one to five years old, purely from memory or from small 3″ x 5″ cards which list a few dates and little else. Such negligence may cause the unlucky victim

* Reprinted from The Milwaukee Medical Times, August, 1940.

of an examining attorney considerable discomfort.

Contrast this picture with that of the medical witness who can testify from a carbon copy duplicate of all his reports, supplemented by a card system which itemizes each office, house, or hospital call, and the details of the treatment afforded therein.

Outside of the field of industrial surgery there are occasions when any doctor may need an adequate record system, and need it badly. The most competent surgeon is never entirely free from the threat of the malpractice suit. In such an event his records are his only real protection. To the patient who may charge a physician with negligence, there is no answer like a complete file of the case, written while the facts were still fresh, and giving dates of injury or illness, and time, place, and type of treatment.

Less spectacularly, in the ordinary private case the doctor should be able to duplicate prescriptions given out perhaps years before, if only because of the psychological effect on the patient. Surely the doctor owes it to himself and to the patient to keep complete records of every sample passed out, every prescription given.

Granted, then, that there is a definite need for a real system of taking case records, what should this system be at its best? It must be simple and yet complete; a well-trained secretary must be able to handle it, and it must get down on paper all the pertinent facts of any case.

Such a system is given below; it is one which has stood the test of time and usage in an office where the volume of compensation cases is great and one which may be adapted easily to any practice.

The Case History

1. Obtain complete personal data.
   a. Patient's name—age—sex—color.
   b. Patient's address—telephone number.
   c. Patient's employer (necessary in compensation cases—valuable aid to collections in private cases.)
   d. Employer's address—telephone number.
2. Obtain history of present accident or illness.
   a. Where was patient at time of accident or illness?
   b. Was he working, and if so, at what address?
   c. Day and hour of accident or illness—A. M. or P. M.?
   d. Patient's description of accident or illness.
   e. If injury, what part was injured? (finger, toe, etc.)
      Was it left or right?
      (In case of laceration how deep does the patient believe the laceration to be, and how much bleeding was there? If a weight dropped on any part of the patient, approximately how many pounds was the weight?)
   f. Was the patient treated by any other doctor? Who? When?
   g. Was first aid rendered? Where? What was done?
3. Obtain past medical history.
   a. Has the patient ever had any similar injury or illness?
   b. If so, what? When? (Get dates.)
   c. Is there any connection between past and present injury or illness? (Your opinion.)
4. Your examination (To be filled out by physician only.)
   a. In case of accident: part injured, left or right, description (such as ecchymosis, length and depth of any lacerations and their location, limitation of motion, if any, etc.)
   b. In case of illness: symptoms.
5. X-ray examination.
   a. Were x-rays taken?
   b. When? (Give date) By whom?
   c. Findings.
6. Treatment.
   a. In case of laceration, were dermal sutures used? Pressure bandages? Antitetanus? (If patient refused antitetanus serum it is wise to have the secretary type out a slip to this effect, have it signed by the patient, and attach it to the history card.)

b. In case of contusions, sprains, fractures, etc., were elastic bandages used? Wooden or plaster splints?

c. What prescriptions were given, if any?

7. Remarks (Your opinion.)

a. Prognosis.

At first glance the outline given above may seem to be complicated rather than simple, and to involve many unnecessary details. But upon use it will be found to resolve itself rapidly into a few main headings, and it is possible, after following the detailed outline a few times, to progress from one to the other of these headings, omitting no salient detail, with a minimum of writing and a maximum of efficiency.

Familiarity with the outline soon will make quite unnecessary the copying of any of the headings; habit takes over and the doctor finds himself with an organized procedure for the recording of case histories. His method is smooth and orderly; he knows exactly what he wants to find out, and why.

If a secretary or an assistant is to take this history, it may be advisable to have blanks printed or mimeographed. With such forms any doctor's secretary can take all of the personal history, the patient's account of the accident, and the past medical history. Then the doctor can fill in quickly the details of examination, treatment, and prognosis.

It is always wise, however, for the doctor to read each case history at the time of the examination in order to clarify and corroborate the facts with the patient. Many times a definite change in history is obtained in the privacy of the treatment room.

In the private case, of course, the forms may be greatly simplified; the method of procedure, however, remains the same. But whether it is used in private or industrial practice this method pays real dividends in accuracy, economy of time, and the satisfaction of patients.

UNITED STATES
DEPARTMENT OF THE INTERIOR
Division of Information
Radio Section

109713
WJZ and Blue
8:00–8:30 P.M., EDST
August 21, 1940

"This, Our America"

Program 8

"HEALTH AND EDUCATION"

ANNOUNCER: As the nation turns to its defense, the National Broadcasting Company in cooperation with the National Resources Planning Board presents the eighth program in the series, THIS, OUR AMERICA, in order that you and I may know exactly what resources we have in order to defend our shores.

2ND ANNOUNCER: Tonight, THIS, OUR AMERICA tells you where we stand in regard to:

VOICE: Education and health in America!

MUSIC: SNEAK UNDER.

NARRATOR: Since Thomas Jefferson, America has wished to provide a free and progressive education for every person in the land. It is a far cry from the little red school house of seventy-five years ago to the quarter of a million elementary schools and the 29,000 high schools—

JOE: (Interrupting) Hello, remember me? Joe, the average guy?

2ND NARRATOR: Glad to see you here again, Joe!

JOE: I know I interrupted you fellows, but I just had to. You were going to tell us the number of schools and colleges and the number of pupils and the number of teachers?

2ND NARRATOR: Yes, we were.

JOE: But we know we got a lot of schools. And we've never complained about paying taxes for them so that our kids could get a decent education. Yeah, we know all that. But—

OUR NATIONAL DEFENSE . . . AN EDITORIAL

In times of national emergency, as in times of peace, the record of cooperation of medicine with the desires of the government is a record of long, arduous and high public service. It is the determination of medicine that never now nor in the future shall it be less.

The work of medicine in the depth of the Depression was termed "a grand story" by Harry Hopkins. The same effort was the cause for a special tribute in 1936 by President Roosevelt who said in part: "Let me with great sincerity give the praise which is due the doctors of the Nation for all that they have done during the depression, often at great sacrifice, in maintaining the standards of care for the sick and in devoting themselves without reservation to the high ideals of their profession."

The work of medicine in the World War received commendation from every possible official source.

The work of medicine in the present time of mobilization will also prove by deed the devotion of medicine to our country and to the great ideals of humanitarian service to all, which have ever motivated its disciples.

* * *

The national period of stress should not be used for any purpose less than worthy. The accompanying broadcast, sponsored through the Department of the Interior, with the basic theme of national resources and defense, presents a picture not only exaggerated but with limited application. It may take longer to thread one's way fifteen miles through congested urban traffic to a hospital than it takes a farmer's car to speed thirty miles to his nearest hospital. Certainly the broadcast does not portray the work and achievements of medicine as we know them in Wisconsin or in our neighboring states.

We submit that the broadcast presents a picture distorted until it is less than worthy of the sponsorship of our government.

We express the hope that its issuance does not presage the use of national defense needs to impose upon the people of America systems of impersonalized, mechanized medicine that have long characterized the governments of Europe.

We can mechanize for death—we must personalize for health and, may we add, for national defense.

1st Narrator: But what, Joe?

Joe: I've been doing some thinking about what it means to be educated in 1940. I'd like to shoot off my mouth about it.

2nd Narrator: This is your program, Joe — not ours. Go ahead.

Joe: Well, if I had a kid what would I like to have him taught besides the regular things all kids are taught in school? It seems to me three things have to be taught—it seems to me they're more important than anything else right now.

2nd Narrator: What are they, Joe?

Joe: First, I keep asking myself: Are the kids in school, are the boys and girls in college—are they being taught to *think?*

Narrator: What do you mean, Joe?—think?

Joe: Well, you pick up a half a dozen papers—you can get a half a dozen points of view about anything happening today—you listen to the radio —one guy says one thing, one guy says another —or take short wave—one side tells you they're right—the other side tells you the opposite. All the education in the world isn't going to do any good unless a fellow can take all these points of view and-and iron 'em out in his mind—and-and know propaganda from the real McCoy—unless he can find the facts and come to his own opinion first hand. That's my idea of what I'd teach my students if I were a teacher.

2nd Narrator: Joe, what you're asking for is to teach—judgment?

JOE: That's it! Judgment! Otherwise, anybody can come along and fill us with a bunch of half-baked notions and we accept them . . . and haven't any minds of our own. Well, you're the boys with the facts. Tell me, are the young folks—the ones who'll have to do the work and the fighting to defend us—are they being taught to judge for themselves in this cockeyed world?

NARRATOR: Yes, Joe—

JOE: How?

NARRATOR: All sorts of ways, Joe. By discussion groups, by debates, by forums, and by courses especially designed to make people form individual judgments.

JOE: OK then.

2ND NARRATOR: Go on, Joe. What's the next thing you think makes for a real education?

JOE: Well, a fellow's got to be taught *what* he's defending. Dates in history classes are ok by me; who was Pocahontas and what famous words did Nathan Hale say, that's ok, too. But more than that, kids should be taught *what* it means to be an American. They ought to be taught how words like freedom and liberty are more than just high-sounding words; kids ought to be taught *what* in their own lives, from the time they brush their teeth in the morning till the time they say their prayers at night, brings them this freedom. Well,—are our educators teaching them *what* we are defending?

NARRATOR: Yes, Joe. I think so . . .

JOE: How?

NARRATOR: All over the country, Joe, teachers are putting more emphasis on what America *means* than on what America has *done* historically in the past. Students are taught today exactly what the Constitution means — the right to choose your own representatives and your own Senators and your President; the right to speak freely and the right to print your ideas and the right to worship as you see fit. Educators realize today that a student must be taught what security means, security to work, to be healthy, to live a better life in every way. That's how students are being taught what they're defending.

JOE: That's swell!

2ND NARRATOR: Go on, Joe. What's next on your little list?

JOE: Well, we're going to need a lot of industrial workers—

NARRATOR: I see what you're driving at, Joe. Vocational training?

JOE: Yeah.

2ND NARRATOR: The President has given Mr. Hillman of the Defense Commission the job of seeing to it that young men and women are trained to become skilled workers in many fields. All over the country new vocational schools are being opened to teach crafts to thousands of enrollees. We're making great progress.

JOE: Well, then, I'm satisfied. Only there's one thing more that I think educators ought to be doing.

NARRATOR: What's that, Joe?

JOE: Well, we got to lead the world in Science. We got to know how to make the finest machines for defense. And we got to use Science so that after this defense program is over, we can go on living better—better homes, better soil, better food—better everything in America. That means we got to have men who know about—well, about complicated things—like trade—and—and—economics—and giving everyone a break. That means we got to have our colleges educate men to become leaders, doesn't it?

2ND NARRATOR: Well, 98 thousand college teachers in this country—and that's an awful lot of college teachers, Joe—have just those things as their aim.

JOE: Then I feel ok! If a guy is taught to think clearly, to think for himself; if he's taught what he's defending; if he wants to work in industry to help defense and there are schools to teach him how to work; and if colleges educate men to be leaders of the people—that's what education means to me in 1940!

NARRATOR: And to all of us, Joe. And that's just what we're doing.

JOE: (With an amused sigh) Gosh, I've certainly been talking a lot. . .

2ND NARRATOR: Then suppose we talk about *you*, Joe.

JOE: Me? Say, you're wasting good radio time talking about me. I'm just a minnow in the pond. What's important is what resources and how many resources this country needs—

NARRATOR: We know all that, Joe. But no resource is as important as you.

JOE: I don't get you.

NARRATOR: You're the greatest single resource in America. You're a living human being. You think the thoughts, you dream the dreams, you put them into effect. You *are* America, — 132 million Joes.

JOE: Say, I guess you got something there. . .

2ND NARRATOR: You bet we have! And since you're the greatest single resource of America, it's vital that you learn how healthy you are.

JOE: Me? I'm in fine shape.

NARRATOR: But how about the other Joes in the country? Total defense depends on men like you. The men and the women who work in the fields and in the factories; the men in the Army and the Navy?

JOE: Then let's have the lowdown. Where do we stand on health?

NARRATOR: Part of the story, Joe, isn't pretty. Suppose we tell you the bright side first.

MUSIC: SNEAK UNDER.

NARRATOR: In the last fifty years, we have made amazing gains!

VOICE: Yellow fever has been completely wiped out. . .

2ND VOICE: The plague has been completely wiped out. . .

3RD VOICE: Not so long ago, tuberculosis was the fourth most deadly disease in the United States. Today it has dropped to seventh place. Even in the past year this disease has declined almost five per cent.

4TH VOICE: There has been an amazing decrease in the number of infant deaths.

VOICE: Today scarlet fever and diphtheria, malaria and pellagra, typhoid and infantile paralysis are the lowest on record.

2ND VOICE: Our death rate is progressively lower each year. And less people died in the United States in 1938 than in any year before.

3RD VOICE: We have the greatest hospitals in the world. Institutions like Johns Hopkins, the Mayo Institute, the Presbyterian, Belleview, Trudo Sanitorium, the Massachusetts General Hospital are without peer in the world.

4TH VOICE: There are almost 170,000 physicians in the United States. There are over 200,000 nurses in the United States.

VOICE: Every year five thousand young men and women take the oath of Hippocrates to save the lives of their fellow Americans.

2ND VOICE: With all these doctors, nurses, hospitals, and with such medical inventions and discoveries as sulfanilamide—the iron lung—vitamin concentrations—the bronchoscope—there is no reason why America should not become the healthiest nation on the face of the earth!

NARRATOR: Sounds good, doesn't it, Joe?

JOE: I'll say! But let's have the catch to it—

2ND NARRATOR: What do you mean, Joe?

JOE: I know you boys by now. You don't pull any punches. Where's the rub?

2ND NARRATOR: Joe, if these were normal times we live in, we could take up our health problems one by one and over the next twenty-five years solve most of them. But these are not normal times. Just as we are doubling and tripling our industrial expansion, and rushing our plans for armaments, so we must double and triple our fight for life. We can't afford to wait twenty-five years to solve these problems.

JOE: What problems?

NARRATOR: Well, here's one: Each year one million Americans die who could be saved.

JOE: No!

MRS. WILLIS: (Listlessly) Yes, Joe. What this gentleman just said is right.

2ND NARRATOR: Hello, Mrs. Willis. Glad you could come.

MRS. WILLIS: (She has a slight southern accent. Her voice is middle-aged) I want the folks out there to know. I think they have a right to know.

NARRATOR: Suppose you tell your story, Mrs. Willis.

MRS. WILLIS: Henry—he was my husband—Henry and I lived in the South. We lived in a little frame house; had a few chickens; a little truck garden. Henry didn't make much money. Three years ago he took sick, real bad. He'd walk around, all twisted with pain.

2ND NARRATOR: Were there doctors in your neighborhood?

MRS. WILLIS: There were doctors. Henry went to every doctor in the county. He couldn't blame the doctors. The doctors didn't make much more money than Henry did. They didn't have all those expensive machines to tell what ails a person. But they all looked at him and said it was his liver. They used to give him medicines until our bathroom shelf was just piled with medicine bottles. But it didn't help Henry. The pain got worse. He took to bed. Finally he couldn't stand the pain. We didn't have no car and I knew that I should have taken him to a hospital long before this—a big hospital where they had those expensive machines and real big doctors they call—

NARRATOR: Specialists.

MRS. WILLIS: Yes, specialists. But the nearest real big hospital was three hundred miles away. We didn't have the money to get him there.

JOE: Wait a minute. You mean to say the nearest hospital was three hundred miles away?

MRS. WILLIS: Yes, young man. When Henry took to bed and was yelling with pain, I got really scared and I called in my neighbor. He was an undertaker, Jim was. I asked him to drive Henry up to this big hospital in his—in his—(takes deep breath for control) That was the only way to get him there—Henry lay down in it all the way to the hospital—When we got to the hospital, Jim and me sat in the waiting room while they examined Henry. We waited a long time.—

NARRATOR: What did they tell you?

MRS. WILLIS: They didn't say at first. They asked me how long Henry'd been like this. And I said three years. And they asked me why we brought Henry to the hospital only now after three years. I told them how we didn't have any hospital where we come from. I told them how Henry used to sometimes walk three miles to the nearest doctor and no doctor knew what ailed him. Then the doctor told me what was the matter with Henry. He said it was—cancer.

JOE: Gosh . . . That's tough! . . .

MRS. WILLIS: Yes, young man. And they couldn't do anything for him now. The doctors said we'd brought him here two years too late. They said that two years ago had there been a hospi-

tal close to where we come from, he might have been cured . . . so we took Henry back. The ride was too much. He died in the hearse before we got home.

NARRATOR: Thank you, Mrs. Willis.

2ND NARRATOR: The disease that took your husband, Mrs. Willis, need not kill if discovered in time. If in every state, cancer centers were built and equipped; cancer centers in each state where anyone, rich or poor, could be assured of treatment . . .

MRS. FOSTER: How well I know that!

NARRATOR: Why, hello, Mrs. Foster. Glad you could come. I wish you'd tell your story.

MRS. FOSTER: When I discovered the lump in my breast, I went right to the New York State Tumor Clinic in Buffalo which was only 20 miles away. They told me it was cancer. They told me I came in plenty of time. They said radium. I had no money for radium, but they gave it to me free of charge. For two years I kept coming back for treatments and I'm all right now. There's no reason why everybody shouldn't have a place like that to go to in every state in the Union.

2ND NARRATOR: Thank you, Mrs. Foster.

NARRATOR: Suppose we listen to what the National Resources Planning Board has to tell us:

VOICE: "Preventive health services for the nation as a whole are insufficient. Hospital and other institutional facilities are inadequate in many communities, especially in rural areas. Financial support for hospital care and professional services is not enough, particularly for people of the lower income groups."

JOE: Let's see if I get this straight—there are too many places in this country that haven't hospitals close by and should have them?

NARRATOR: Every year, Joe, cancer and heart disease are the two principal causes of death. Since we need all the man power we can muster in times like these, should we not prevent many of these deaths through adequate hospitals and clinics open for rich and poor alike?

2ND NARRATOR: And that's only the first problem, Joe. Here is the second:

VOICE: Each year about 14,000 women die from causes connected with pregnancy and childbirth.

JOE: Say, that's fierce!

THOMAS: (He is very young and hesitant) Yes, it is.

NARRATOR: Glad you could come to tell us your story, Mr. Thomas.

THOMAS: It was to be our first baby. My wife was only twenty. The only doctor in the neighborhood was up in the city for a visit. We didn't have any midwife and for seventy-two hours she was in agony.

NARRATOR: Where was the nearest hospital?

THOMAS: Thirty miles away. You see we lived on a farm. Seventy-two hours she kept screaming—three days of labor pains. We wrapped her in blankets, put her in the car and drove to the hospital. But she died on the table. The hospital doctor told me she could have had her child and been happy. He was a fine doctor. He said every year thousands of mothers die. He called it a crime. He said one-half to two-thirds of these deaths could be prevented.

JOE: How?

NARRATOR: Dr. Martha Eliot, Assistant Chief of the Childrens Bureau in the Department of Labor, has said:

ELIOT: "There must be facilities that provide for prenatal care of mothers; medical care of mothers and their newborn infants; care given by qualified local physicians with the aid of specialized consultants; assisted by nurses, preferably public health nurses, trained in obstetric nursing procedure. There must be facilities for expert diagnosis and care in diagnostic or consultation centers and in the home—*for any mother, regardless of economics.*"

DOCTOR: We know that's true. Mothers don't have to die.

NARRATOR: I'm glad you came, Dr. Lindley. Will you tell the folks who you are?

DOCTOR: I'm a physician living in Cattaraugus County in the State of New York. Every day in Cattaraugus County, with the cooperation of the County Medical Society, the Milbank Memorial Fund and funds from the Social Security Act, a mother in or near the town of Orleans, regardless of whether or not she can afford private care, is given a thorough prenatal examination. We follow this examination up with monthly check-ups. The baby is delivered by a doctor assisted by a nurse. He watches for all symptoms of blood poisoning, convulsions and hemorrhage. There is no reason why maternity centers for the needy and for rural areas should not be flowering all over the United States.

NARRATOR: Thank you, Doctor.

2ND NARRATOR: The third problem, Joe, is:

VOICE: Industrial diseases and hazards . . .

NARRATOR: We're going to need all the workers we can get in the factories, in the mills and the plants—to make tools, machinery, planes, tanks, ammunition. Hard dangerous work that needs stamina and needs health.

STEVE: (Hard-Bitten, Young and Intelligent) I'll tell the cockeyed world . . .

2ND NARRATOR: Glad you could come here, Steve.

NARRATOR: You can explain the problem as well as anybody.

STEVE: You bet I can. There were four of us brothers. Not one of us weighed less than 180. I worked in the coal mines in West Virginia; Gus

worked in a factory in Ohio, Pete was a swing grinder in a steel mill; Ed worked in the stockyards.

JOE: What happened?

STEVE: Pete was the kid brother—him in the steel mill—he sweated because the furnaces were hot and then he'd come out in the cold when it was winter and he got pneumonia. So he died. Ed, that was my older brother,—him in the stockyards—he gets hog itch—he was laid up for months. Gus—worked on a machine and he knows something is wrong with it. One day the thing goes to pieces, caves his chest in—he dies. Me—last week I began to spit blood and started coughing—the doc says I got silicosis. Well, two of us are dead and Ed and me might just as well be—we ain't no good. And we could have taken on double our weight in any fight.

JOE: Why did it happen!

STEVE: It didn't have to. You got more than fifteen million people working in plants and factories. The less sickness they have and the less chance of accidents the better off this country will be for defense. After all we're the guys that make things run. So what's to be done? So this has got to be done. Educate the workers—the unskilled workers. Teach them to be careful. There ought to be more guys to keep their eyes on workers and train them not to have accidents. There ought to be more laws, laws to keep the factories and the mines safe. There ought to be closer inspection and better cooperation between the state inspectors and employers. And what's most needed is medical care for all the workers—quick care—good care—So a guy like me don't have to run around in circles coughing his lungs out until he gets a doctor.

2ND NARRATOR: Thank you, Steve.

NARRATOR: Now do you see, Joe, how all these little pieces fit together to tell a serious story? Do you see this waste of human life?

2ND NARRATOR: And we're not through. Here's the most important problem of them all.

NARRATOR: Medical care for the medical needy.

WOMAN: (Young, Tired, Bewildered) Yeah . . .

2ND NARRATOR: Glad you came, Mrs. Kolowkowski. Let's hear your story.

MRS. K: I'm twenty-five. Lou works on a construction gang. We pay $16 a month for the flat.

NARRATOR: You have children?

MRS. K: One baby, two years old.

2ND NARRATOR: Where is he?

MRS. K: In the country . . . he's been sick.

JOE: What's the matter with him?

MRS. K: The doctor at the clinic said he must go to the Children's Home in the country. The doctor said he had a heart murmur.

NARRATOR: Had he been sick before?

MRS. K: Five months ago he had a bad ear. He got over that and then he got scarlet fever. We had to send him to the hospital. And he had to stay three weeks more because he got chicken pox. Then he got this heart murmur. If I'd felt well I could have taken better care of the baby maybe.

2ND NARRATOR: You have been sick?

MRS. K: When the baby came I went to the clinic. They found out I had a touch of t.b. They said I should rest. You ask my husband if I can rest.

MR. K: (Young and Bewildered) Hello.

NARRATOR: Can't your wife rest up?

MR. K: Fat chance! I don't know how I'm going to keep on. I owe money. Medicine costs a lot. I got two hundred dollars I got to pay to doctors. God knows where I'll get it.

JOE: How do *you* feel, brother?

MR. K: Me? I can't afford to get sick. I got to work. Getting sick takes every penny. It's sure funny how much we get sick. Maybe it's the flat. No sun, no ventilation. Maybe because we've always been poor and never had any doctors when we were kids. I don't get it. I don't know why our baby's got a heart murmur, anymore than why the wife's got t.b. Funny, ain't it?

NARRATOR: (Sarcastically) Funny, ain't it, Joe?

JOE: No, there's nothing funny about that! The way I see it we're just letting large hunks of our population get sick and die when they might be healthy and alive! Especially now when everybody is needed to put his shoulder to the wheel!

NARRATOR: Yes, Joe. We spend huge fortunes constructing highways, but not enough to take care of our mothers and our children. We spend millions in soil conservation, but what about human conservation? Listen to what the National Resources Planning Board writes:

VOICE: One-third of the nation, those with incomes under $750 a year, is receiving inadequate or no medical service at all. An even larger section of the population suffers from economic burdens created by illness. Among those with low incomes there is more sickness and death, as a result of less healthful living conditions.

2ND NARRATOR: The time has come, Joe, when we must remember that we've got to step up our rate of progress in health. The phrase is "life, liberty and the pursuit of happiness"—the liberty and the pursuit of happiness of the nation aren't enjoyed unless the life of the nation is sound and healthy.

JOE: Well, we've got a job ahead of us! What's to be done?

NARRATOR: Here's what's to be done, Joe:

2ND NARRATOR: There must be a national defense health plan conceived and planned in cooperation with all the people of the United States. This is a democracy. Let the *people* wake up to the fact that health is as important a problem in total defense as building a battleship.

VOICE: Work must be done on slum clearance and housing and adequate relief for all the people . . .

2ND VOICE: There must be enough hospitals and medical care for all people regardless of income . . .

3RD VOICE: There must be a stepping up in our national drive against syphilis, tuberculosis and cancer.

4TH VOICE: In this national defense health plan all pre-school and school age children must be vaccinated against smallpox, whooping cough and diphtheria.

VOICE: There must be expanded clinic and hospital service for prenatal care, for delivery, and for postnatal care.

2ND VOICE: Enforcement of present laws to do away with occupational diseases and hazards, better factory inspection, and a drive to educate workers to protect themselves from accidents.

3RD VOICE: An education program which can reach every one of 132 million people and teach them the importance of reaching a Doctor at the first sign of illness.

JOE: Are these things being done?

NARRATOR: Too many of us are expecting miracles to happen overnight because of defense. You can't build a battleship in a month nor can you make progress in national health in a few weeks.

2ND NARRATOR: But we are beginning strongly. Harriet Elliott of the Defense Commission has already begun work on these problems. She has five authorities as advisers on nutrition, on prices of food, on public health, on housing. A few weeks ago a meeting was held in Washington at which you, the People, sent your Delegates to represent you. These Delegates were from all walks of life; they represented trade unions, schools, nursing bureaus, farmers, and industrial workers. They sat for hours and made suggestions to the Defense Commission as to what to do. Here's what they suggested:

VOICE: Low labor standards threaten efficiency!

2ND VOICE: Low levels of health and nutrition menace the vigor of our people!

3RD VOICE: Exclusions and prejudices menace national unity!

4TH VOICE: Low living standards and lack of understanding and participation in democracy menace democratic values!

NARRATOR: And, Joe, there are recommendations that will help to start things going. They're going to work for more vigorous local ordinances for housing, health and sanitation and for enforcing such ordinances. Relief authorities are being asked to set housing standards for families on relief. Local medical societies are being urged to study medical services locally to determine the best distribution between civilian and military requirements. They want to make sure civilian needs in the community will be taken care of.

JOE: Well, that sounds pretty good to me.

NARRATOR: Yes, Joe, it shows the ability of democracy to take a problem in which we are all concerned and to solve that problem—not for the *few* but for every individual among us . . .

JOE: It looks as though the people can help in most of this work.

NARRATOR: It will have to be that way, or it will fail. If the people of this country wake up and realize how important their health is to total defense, they will do something about it. It needs education. It needs organization. It needs money. We have got to stop wasting human life! And with your help, Joe, we'll do it!

MUSIC: UP AND OUT.

PREPAREDNESS POLL

Physicians are urged to return IMMEDIATELY, if they have not already done so, the preparedness questionnaire of the Committee on Medical Preparedness of the American Medical Association. The entire medical preparedness program of the Association revolves around the data obtainable from these questionnaires.

Any Wisconsin physician who has failed to receive this material should request it from the American Medical Association, 535 North Dearborn St., Chicago, Ill.

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An Appeal by the Veterans of Foreign Wars of the United States*

By GEORGE H. REDDICK, M. D.

Surgeon, Veterans of Foreign Wars of the United States, Department of Wisconsin, Wabeno

THIS is a message to physicians in Wisconsin, given in my capacity as Surgeon for the Department of Wisconsin, Veterans of Foreign Wars of the United States, and of the Disabled American Veterans of the World War.

During the years since the World War I have had occasion to meet the medical problem of many veterans. They need your help and I ask you to give it to them.

Permit me to quote from statistics. During the World War 4,791,172 were in uniform. Of these, 342,072 receive compensation for service-connected physical and mental disabilities, that is less than 9 per cent. In other words, four and one-half million served and four million receive nothing. In spite of the accusation, the war veteran is most definitely *not* a Treasury raider.

When a veteran does file a claim for compensation for disability due to service he meets up with many strange decisions. I speak only of those by the medical section of the Veterans Administration. Here he needs your help and my purpose here is to request that you give it to him. May I cite a few instances. For example, the medical section of the Veterans Administration rules, "that no living veteran has a physical disability due to gas." I served in the front line with a battalion of infantry and I have examined veterans for more than twenty years. I do not believe that statement. A veteran was told that dacryocystitis was not due to service. He went to a private physician who verified, by an accepted medical authority that such an eye disorder was common among war veterans, due to gas. The Veterans Administration refused to accept it.

A veteran appeared before a rating board and the doctor on the board reviewed an x-ray picture of the veteran's chest, then told him he had a "nick in his heart." Of course the veteran was in no position to agree or disagree.

Another veteran has a brain disorder due to syphilis. His mother and sisters have positive Wassermanns, yet his dependents are denied pensions on the statement of the medical section of the Veterans Administration that his syphilis is due to his own misconduct. Yet no scar of chancre is found. His condition is congenital and was aggravated by service.

I am not pleading the cause of the malingerer. For him I have no more sympathy than have you. This state abounds with cases of veterans that need medical aid in completing their claims. I ask you to give it. For all any of us know, a new flock of veterans may be in the making. Let us take care of the present ones.

It is fully appreciated that many of you object to veterans hospitals operated by the Government. I realize it is a form of socialized medicine. Any practice for a stipulated fee per month irregardless of number of cases treated is in that class. The doctor working for a monthly stipend for the Government is in the same class as a private physician with a "contract practice." Following the World War an attempt was made to treat veterans by "contract practice" among private physicians. It was a headache and did not work.

I know these federal hospitals take the veteran practice away from private practitioners and many of you object. It seems to be the only solution, but, it should not cost $4,000 per year per man as one of you learned. These veterans hospitals do compete with physicians in another fashion and you and the veteran will be in accord in urging it be discontinued. I refer to the practice of treating non-veteran elements in veterans hospitals (WPA and CCC enrollees, railway and postal employes, city firemen and policemen, Great Lake sailors, Public Health Service and U. S. employe compensation commission cases, etc., etc.). When a federal hospital accepts municipal employes the dollar is taken out of your pocket. The hospital in Milwaukee, for instance, treats 500 per month. They should be treated by private physicians.

You who are veterans; these men need you now as much as they did in 1917–1919. You who are not, will you please the next time you are brought in contact with a veteran, take a minute to review his medical history and its military connection, and give him the benefit of your professional opinion. He needs it.

* Printed at the request of the State Commander, Veterans of Foreign Wars of the United States.

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BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Dermatologic Treatment in General Practice. By Marion B. Sulzberger, M.D., assistant clinical professor of dermatology and syphilology, New York Postgraduate Medical School and Hospital, Columbia University, and Jack Wolf, M.D., attending dermatologist and syphilogoist, New York Postgraduate Medical School and Hospital, New York City. Cloth. Price, $4.50 postpaid. Pp. 675 with 65 illustrations. Chicago: Year Book Publishers, 1940.

This is a book written for the general practitioner by a specialist. As Fred Wise states in the foreword, until now there has been no available text in which there is a brief detailed description of the management of the more common skin diseases. The development of the book is very logical.

A very detailed account of the principles of topical medication includes about 250 prescriptions. There is a short discussion of physical types of therapy, such as radium, x-ray, etc. Inasmuch as these forms are limited to the specialist, only the indications and results are given.

The second part of the book deals with the more common diseases of the skin. The chapters on Eczematous Dermatoses and Atopic Dermatitis are exceptionally well outlined. In all of the chapters there is enough clinical description of the diseases, and they are so arranged with the differential diagnosis that the practitioner should be able to arrive at a logical diagnosis. The section on Pyodermas includes an excellent chart which should be very helpful in understanding the underlying pathology.

Chapter 11, on the common tumors of the skin, presents the differential diagnosis for all the precancerous lesions, with directions as to the management of the malignant lesions. It is properly stressed that the treatment of such lesions requires a specialist.

In the section on Pruritis there is a very ingenious table indicating location, cause and treatment. Chapter 13, which is of considerable importance to the general practitioner, deals with drug eruptions. The detailed table listing the various etiologic agents and the types of eruptions should be helpful in making a differential diagnosis. The third section, dealing with syphilis, outlines the early diagnostic procedures, a clinical description, and plans of therapy. The section on late syphilis includes a plan for fever therapy.

The book is well illustrated with photographs which are so grouped as to aid in the differential diagnosis. In addition to a good index of subject material, there is an index of prescriptions so that, knowing the diagnosis, one may refer to the proper pages and choose a suitable prescription.

This book should be a valuable addition to the general practitioner's library. G. A. C.

Clinical Methods; a Guide to the Practical Study of Medicine. By Sir Robert Hutchinson, Bart., M.D., LL.D., F.R.C.P., consulting physician to the London Hospital and to the Hospital for Sick Children, president of the Royal College of Physicians, and Donald Hunter, M.D., F.R.C.P., physician to the London Hospital. Ed. 11. Cloth. Price, $5. Pp. 622, illustrated. New York: Paul B. Hoeber, Inc., 1940.

This handy little volume describes methods of clinical investigation. It deals with history taking, the eliciting of physical signs at the bedside in adults and children, and various laboratory procedures which are of practical value in the investigation of disease.

The present edition has been thoroughly revised and brought up to date. A wealth of material is here available in simple clean cut language. As is usual with English clinicians, stress is placed upon observation and other simple means of perception for study of the patient, and arriving at logical conclusions, thereby placing these matters in their proper sequence ahead of mechanistic means for the diagnosis of disease.

This volume will be useful as a reference book for physicians. Perhaps because much of the material is elementary, it may be of greater value to medical students than to graduates, but for either it can be recommended. There are several illustrations but no bibliography. O. O. M.

Medical Nursing. By Edgar Hull, M.D., F.A.C.P., clinical professor of medicine, Louisiana State University School of Medicine, visiting physician, Charity Hospital of Louisiana at New Orleans; Christine Wright, R.N., B.S.; and Ann B. Eyl, B.S. Cloth. Price, $3.50. Pp. 588, with 168 illustrations, including 11 color plates. Philadelphia: F. A. Davis Company, 1940.

The authors state that the aim of this book is "to impart to the student nurse an understanding of the principles of general medicine, to furnish her with brief yet accurate descriptions of the important diseases which fall within the realm of internal medicine, and to indicate the medical treatment, nursing care, and dietary management of these diseases." General principles rather than details are stressed since the authors believe that "if fundamentals are understood details may be remembered much more easily than if they are merely memorized." Each disease is considered from the viewpoint of the doctor, the nurse, and the dietitian.

The first unit in the book deals with the basic principles of medical nursing, the following eight

BRIEF HISTORICAL NOTES ON MEAD'S CEREAL AND PABLUM

HAND in hand with pediatric progress, the introduction of Mead's Cereal in 1930 marked a new concept in the function of cereals in the child's dietary. For 150 years before that, since the days of "pap" and "panada," there had been no noteworthy improvement in the nutritive quality of cereals for infant feeding. Cereals were fed principally for their carbohydrate content.

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units are discussions of important diseases arranged and grouped according to the various systems of the body, and the remaining five units deal with diseases due to emotion, deficiency of nutrition, metabolic disturbances, allergy and physical and chemical agents, and infectious agents. In addition there is an appendix on the Nursing Care of Pneumonia which has been reproduced from **Handbook on the Nursing Care of Pneumonia** (Second Edition) issued by the Bureau of Pneumonia Control, Division of Communicable Diseases and Division of Public Health Nursing of the New York State Department of Health. Each unit includes a list of correlated references. The table of contents is adequate, and the book is well indexed.

The subject matter is attractively arranged in two columns to the page, the print is easy to read, paragraph headings are readily discernible, and the illustrations clarify and explain the text. The vocabulary is clear, definite, and concise.

An objection may be made to the inclusion of detailed diets since specific diets in certain diseases would not be applicable to all situations. V. E. W.

The Diagnosis and Treatment of Pulmonary Tuberculosis. By John B. Hawes, 2d, M.D., late president of the Boston Tuberculosis Association, and Moses J. Stone, M.D., assistant professor of medicine, Boston University School of Medicine. Ed. 2, revised by Dr. Moses J. Stone. Cloth. Price, $2.75. Pp. 260 with 75 illustrations. Philadelphia: Lea & Febiger, 1940.

This brief textbook may be described as giving, in most instances, the essential details and information, as it is presently interpreted, regarding the diagnosis and treatment of pulmonary tuberculosis.

Obviously, because of the brevity with which certain important conditions are discussed, the reader would need to seek elsewhere for more adequate and complete information. As an example, the important subject of treatment of tuberculous empyema receives only scant mention under the discussion of pneumothorax and oleothorax. More recent diagnostic methods, namely photofluoroscopy with the miniature 4 x 5 inch films and fluoroscopy of the lungs, are not discussed. However, for the physician interested in the essentials of pulmonary tuberculosis this book will adequately serve its purpose. R. H. S.

Gynecological and Obstetrical Pathology; With Clinical and Endocrine Relations. By Emil Novak, A.B., M.D., D.Sc. (Hon. Dublin) F.A.C.S., associate in gynecology, Johns Hopkins Medical School; gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore, etc. Cloth. Pp. 496 with 427 illustrations. Philadelphia: W. B. Saunders Company, 1940.

This book has been written from a storehouse of personal experience over a long period of years in the pathology of obstetrics and gynecology as conducted in the personal laboratory of the author at the Johns Hopkins Hospital. It is one of the best volumes that has ever been written upon this subject; its publication needs no defense; and, I do not hesitate to recommend it to every practitioner of obstetrics and gynecology and others interested in this subject as I feel it should be made a part of their library. R. E. C.

The Virus; Life's Enemy. By Kenneth M. Smith, F.R.S. Cloth. Price, $2. Pp. 176, illustrated. Cambridge: At the University Press; New York: The MacMillan Company, 1940.

The story of the "filterable viruses" is simply told by the author with clear statements of our knowledge of what they are, methods of study, diseases produced both in plants and animals (including man) and prevention and control. Excellent illustrations and brief presentation of the investigations of various authors add greatly to the interest of the book. The absence of any bibliography seems an error to the reviewer even though the book is intended for the general public. P. F. C.

Applied Pharmacology. By Hugh Alister McGuigan, Ph.D., M.D., F.A.C.P., professor of pharmacology and therapeutics, University of Illinois, College of Medicine. Cloth. Price, $9. Pp. 914, illustrated. St. Louis: The C. V. Mosby Company, 1940.

This text on "Applied Pharmacology" contains a mass of information which by the aid of its index should be a useful treatise. The system of classification employed by the author appears quite inadequate in places, e.g., under "antisyphilitic drugs" there is found such substances as radium, iron, lead, aluminum, germanium dioxide, etc. (pp. 801–823).

Certain errors in chemical formulas appear, probably due to oversight in proofreading, which might lead the uncritical to a repetition of mistakes.

A number of traditional errors in points of view and in facts appear to be taken uncritically from other texts, e.g., on page 535, there is found the statement: "Habitués may acquire a tolerance (for

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cocaine) that may reach as high as 2½ Gm. a day" —a figure also given in Sollmann's Manual. A critical perusal of original literature on this subject by competent writers reveals the fallacy of this current idea.

The author's quotation of Pope, "Whoever thinks a faultless piece to see, thinks what ne'er was, nor is, nor e'er shall be," pleads eloquently for leniency in criticism. A. L. T.

The Emperor's Itch; the Legend Concerning Napoleon's Affliction with Scabies. By Reuben Friedman, M.D., assistant professor of dermatology and syphilology, Temple University School of Medicine, Philadelphia. Cloth. Price, $1.50. Pp. 82, illustrated. New York: Froben Press, 1940.

This is an essay in book form which tells about the pruritic rash which affected Napoleon and which was very probably quite an annoyance. It may have started as scabies. Secondary changes undoubtedly took place as a result of long continued scratching and rubbing. The author thinks he may have had dermatitis herpetiformia.

There is no suggestion that the rash affected the outcome of any of his battles. It probably did not lead to his taking the usual left-hand-in-the-tunic pose. No mention is made of Josephine.

The book is well written and well printed. R. L. M.

Pharmacology and Therapeutics. By Arthur R. Cushny, M.A., M.D., LL.D., F.R.S., late professor of materia medica and pharmacology in the University of Edinburgh, thoroughly revised by C. W. Edmunds, A.B., M.D., professor of materia medica and therapeutics in the University of Michigan, Ann Arbor, Michigan, and J. A. Gunn, M.D., D.Sc., F.R.C.P., professor of pharmacology in the University of Oxford, Oxford, England. Ed. 12. Cloth. Price, $6.50. Pp. 852, illustrated with 66 engravings. Philadelphia: Lea & Febiger, 1940.

The twelfth editing of this established text consisted primarily in the addition of approximately fifty pages of material concerning newer therapeutic agents (sulfanilamide, hormones, vitamins) which have been developed in the elapsed four years since the eleventh edition. Complete alteration of the older subject matter has not been attempted although minor changes have been made. The sketchiness with which some phases of the subject are treated bears witness to the preface statement and the further generalization that the constant increase in the scientifically recognized materia medica makes it difficult to combine the essentials of both experimental pharmacology and therapeutics in 900 pages. Certain "text book errors" are perpetuated, especially regarding the actions of drugs on man, the original error arising from unwarranted transfer of evidence from experiments on a single animal species.

Considered in its entirety the volume is a good text, the revision reasonably satisfactory, and the statements regarding drug action as critical as can be expected from authors who cannot assume claim to first hand knowledge of all phases of a very complicated field. M. H. S.

Principles of Hematology. By Russell L. Haden, M.A., M. D., chief of the medical division of the Cleveland Clinic, Cleveland. Ed. 2, thoroughly revised. Cloth. Price, $4.50. Pp. 362, illustrated with 321 engravings on 167 figures, including 173 original photomicrographs and 100 original charts and drawings and a colored plate. Philadelphia: Lea & Febiger, 1940.

This book clarifies and organizes the often confusing problems in hematology frequently met in general practice. A successful attempt has been made to trace the formation, activity, and fate of the formed elements of the blood in health and in disease. Excellent working diagrams and numerous plates serve well to illustrate the pathologic physiology. All but the most elaborate laboratory tests are described simply and with emphasis on their practical application. The book is not encyclopedic in nature but a well organized outline to fit the needs of the general practitioner.

The last 110 pages of this 350 page volume are devoted largely to case records which briefly summarize the clinical picture, differential diagnosis, laboratory findings, and management of the common hematologic disorders. Occasional typographical errors and omissions are encountered, e.g., no mention is made of the normal platelet count in infectious mononucleosis as opposed to the greatly lowered platelet counts in the acute leukemias.

The popular demand for organization and simplification of hematology justifies the printing of a revised edition a year after the first edition. J. B. B.

Simplified Diabetic Manual; with 163 International Recipes (American, Jewish, French, German, Italian, Armenian, etc.). By Abraham Rudy, M.D., associate physician and chief of the diabetic clinic, Beth Israel Hospital, Boston; instructor in medicine, Tufts College Medical School; consultant in diabetes, Jewish Memorial Hospital, Roxbury, Mass., and Jewish Tuberculosis Sanatorium, Rutland, Mass. Cloth. Price, $2. Pp. 216, illustrated. New York: M. Barrows & Company, Inc., 1940.

This manual, written for the diabetic patient rather than for his doctor is one of the most complete and one of the most clearly and simply written of any book of this type which this reviewer has yet seen. It contains specific practical suggestions for the hygiene of the diabetic individual, with answers to all questions which might arise in connection with his disease. No attempt is made to discuss the relative merits of various forms of diet therapy, since this should properly be the decision of the physician. Of particular value, however, is the inclusion of 163 recipes for people of all nationalities. A book of this sort should be encouraging to diabetic patients because emphasis is placed upon the fact that diabetics can live a near-normal type of life with a normal life expectancy. This volume is to be recommended to physicians to be used as a guide for their patients. E. S. G.

(Continued on page 889)

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Synopsis of the Principles of Surgery. By Jacob K. Berman, A.B., M.D., F.A.C.S., assistant professor of surgery, Indiana University School of Medicine, Indianapolis. Cloth. Price, $5. Pp. 615, with 274 illustrations. St. Louis: The C. V. Mosby Company, 1940.

This small volume in a very interesting and vivid manner reveals more information within its 600 pages than any other surgical text. The author makes excellent use of maxims. Surgical principles are stressed and at all times there is a correlation between the basic sciences and clinical surgery. In short, this is a book on the science of surgery and no attempt is made to discuss surgical technic in detail. This book is ideal as an outline of surgery for students and may be used to advantage for review by surgeons before taking surgical board examinations. At the end of each chapter there is an excellent bibliography for further reading.

It is difficult to single out any one chapter; but if any are to be chosen, those devoted to body fluids, acid base balance, hemorrhage and shock are outstanding. The simplicity but completeness of discussion is amazing, and the subjects have been brought up to date. A. R. C.

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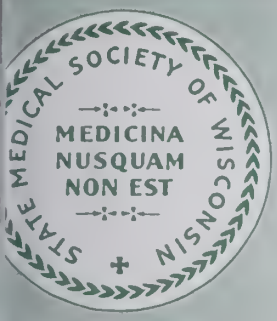

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CANNED FOODS AS SOURCES OF THE ESSENTIAL NUTRIENTS

● Early in this century, the existence of "accessory food factors"—the vitamins—was demonstrated by animal experiments (1, 2). Since that time, building upon information established by earlier investigators regarding the calorie, protein, and mineral needs of man, contemporary workers have developed a practical and fairly complete working knowledge of nutrition. At the present time, the fundamental human dietary requirements are considered in terms of some thirty substances of known chemical composition plus a number of factors whose chemical natures still await determination (3). Likewise, the dietary values of foods also may be discussed in terms of these same essential nutrients.

Viewed from a physiological basis, nutritional failures appear to be conditioned either by consumption of a diet deficient with respect to certain of the essential food factors or to altered processes in metabolism which prevent the efficient absorption and utilization of foods (1). Failures of the latter type can be corrected only by elimination of the defects in metabolism, or by administration of nutrients by routes which permit utilization. However, the vast majority of nutritional failures are associated with the consumption of diets deficient with respect to essential food factors. In the following quotation, the facts regarding malnutrition resulting from faulty diet are concisely stated (1):

> "Three facts concerning nutritive failure are becoming increasingly obvious: first, that it does not come solely from lack of vitamins but from deficiency of proteins and minerals as well; in certain of the lower animals, it comes even from lack of fats; second, that in America it is seldom complete; and third, that it is not, as a rule, the expression of a single nutritive fault. More often it is partial in extent and multiple in nature, with a clinical picture that is correspondingly lacking in detail and hazy in outline."

Although nutritional diseases are manifestations of the prolonged consumption of diets deficient with respect to amino acids, minerals, and vitamins, students of the problem agree (2, 4, 5, 6) that elimination of malnutrition is primarily a problem of increasing the variety of foods regularly eaten. Special emphasis should be placed upon the judicious consumption of familiar foods such as meats, (including glandular organs, poultry, sea food, and fish); eggs; milk in its many forms; milk products; fruits and vegetables; legumes; and the whole cereals and their various products. Thus, in its practical application (7), nutrition may be viewed as "an economic, agricultural, industrial and commercial problem, as well as a problem in physiology."

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REFERENCES

1. 1939. J. Am. Med. Assoc. 112, 2110.
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7. 1935. Quart. Bull. Health Organ. League of Nations 4, 326.
8. 1939. Canned Food Reference Manual, American Can Company, New York.

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STUDIES IN THE AVITAMINOSES

This page is the eleventh of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the November 9 issue of The Journal of the American Medical Association.

The Gingival Manifestations of Vitamin C Deficiency

Gingival lesions are said to be among the most frequent anatomic changes occurring in scurvy. They occur only after dentition has taken place, and are most severe when the teeth are deformed or broken. The pathologic process begins as a hyperemia which is rapidly followed by destruction of the epithelium, and ulceration. Even in the early stages bleeding is readily produced by slight trauma; hemorrhages, while they do not lead to a great loss of blood, may be prolonged and difficult to control. The gum necrosis is usually accompanied by dental porosity. In the advanced stages of scurvy, the teeth are loosened due to destruction of the alveolar process, and the ulcerative lesions may extend to the mucous membrane of the cheeks and tongue. Gangrene has been described as a sequel of advanced untreated scurvy.

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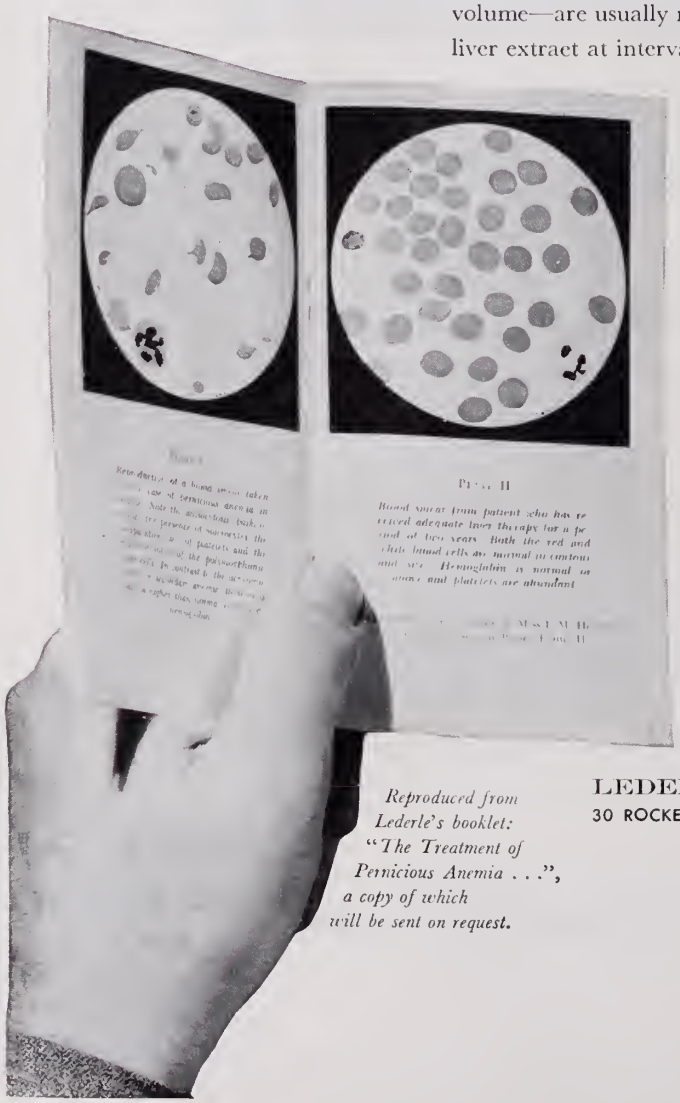

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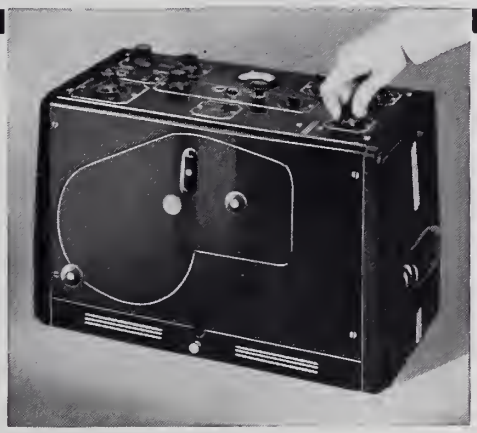

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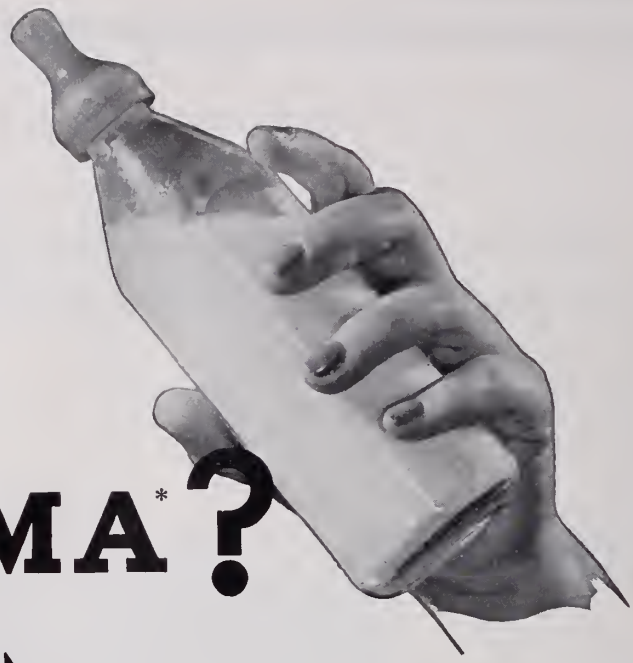

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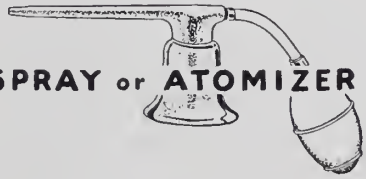

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[1] Sevringhaus, E. L., and Evans, J. S.: *Am. J. M. Sc.* 178:638, Nov. 1929.
[2] Novak, Emil: *Surg. Gynec. & Obst.* 70:124, Jan. 1940.
[3] Schneider, P. F.: *Am. J. Obst. & Gyn.* 37:861, May 1939.

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THE WISCONSIN MEDICAL JOURNAL

VOLUME XXXIX, NO. 11 Copyright, 1940, by The State Medical Society of Wisconsin NOVEMBER, 1940

The Doctor and Democracy*

By EBEN J. CAREY, M. D.

Intelligence Planning and Training Officer, 135th Medical Regiment, Wisconsin National Guard, and Dean and Professor of Anatomy, Marquette University, School of Medicine Milwaukee

Mr. President, Officers, Guests and Members of the State Medical Society of Wisconsin:

PROBABLY at the present time there is more mixed emotion here in America than there has been for years. Right here in our banquet room, there are probably mixed emotions of joy and sorrow because of our living in the United States and relationships abroad. There probably never has been a time when there was more tragic chaos in the world, due to muddled, irregular thinking, and to those who like to mislead for their own personal advantage.

I know of no field where there has been done more consistent good than in medicine. Yet there are those who would like to control medicine from an administrative point of view. I know the difference between technical care and administrative care in medicine when it comes to the United States Army where, unquestionably, excellent work is done; but there is just as much difference as there is between night and day between the individual who fights with a lead pencil and the individual who goes to the bedside and actually cares for the sick.

"Because the Scientist in the Laboratory . . . "

Unfortunately, due to the rapid rise of scientific medicine during the last 100 years, those things that appeal to the senses—sight, hearing, smell, taste and touch—have received greatest prominence in medicine. There has been a tremendous and a glorious advance of what we might call mass medicine, where the state legitimately can prevent disease through police powers. Why? Because the scientist in the laboratory has presented the facts and the evidence of the causes of certain types of diseases.

There is no question that there are many diseases that may be controlled by controlling the water supply and the food supply, waste and sewage disposal, isolation of individuals with contagious disease, and inoculation in order to prevent certain types of diseases. Once we have found, clean-cut, the cause of a disease, whether it happens to be by bacteriological means, whether it happens to be through the diet or an imbalance due to irregular relationships of vitamins (avitaminosis) then many of these diseases may be controlled in the mass.

This has misled some lay as well as professional people who would like to regulate medicine by more laws, laws that would go right down to the bedside and control all types of individual illnesses due either to disease or accidents.

I do not know anything that is more individualistic than a person who is actually sick. It is fine to be sitting here right after a banquet, when we have the feeling of complacency and well-being in our bodies without aches or pains. It is more or less easy to think as a group and to follow the herd, as long as we are comfortable and it is convenient; but it is another thing when the individual, personally, is suffering. There is very little he or she cares about in the control of disease in the mass, unless his or her aches and pains are directly relieved by the physician.

Mass medicine has its legitimate place, and we give credit where credit is due. Pasteur came to this country in 1876 at the time of the Centennial Exposition in Philadelphia, and demonstrated in his test tube certain organisms that definitely cause dis-

* Address given at the annual dinner of the State Medical Society of Wisconsin, Milwaukee, September 19, 1940.

ease. The exhibit was a small one, overlooked by most of the individuals who go to expositions, but it was more or less a harbinger of days to come, because it was the advent of the so-called industrial era. Right after 1876, there was a great development of our industrial plants, mass production, and more or less a genuflection to all of those material advances here in America. By technical methods we have manufactured many products in a short period of time and, at the same time, hoped to control many diseases by these same mass methods.

"There is a Legitimate Function . . ."

So when we talk about mass or state medicine, we recognize very clearly that where the police powers of the state have definitely demonstrated a disease may be controlled, there is a legitimate function for the state. In fact, right here in the State of Wisconsin, practically all of the state laws—I am stating this at the present time mostly for the benefit of your better halves rather than yourselves, and probably it would be just as well that we realize and emphasize it ourselves because it is very easy to forget—were proposed by the medical profession against very vigorous opposition. *At the present time you will hear many public health officials, economists and sociologists who have forgotten the fact that it was the medical profession that really made the United States Public Health Service, the State Health Department here in the State of Wisconsin, and the various other state health departments throughout the forty-eight states in the Union, as well as the various municipal health departments.*

We recognize that the state has its function, but it is one thing to recognize that and it is another thing to be cowed by the attempt to subdue by a power under the control of the state, with medicine entirely within its hands and within its grip, and to neglect—yes, and to crush—not only the individual patient, but the individual physician. If you do not think that will lead to chaos, exactly like that we see abroad, then it has just simply been your misfortune not to have been in the midst of some center where actual socialized medicine was practiced. I had the fortune, or it may have been misfortune, to go through that experience.

"In Austria . . ."

In Austria, in 1931 and 1932, the height of socialism and the height of socialized medicine was reached. The health minister of Vienna was also the professor of anatomy at the University of Vienna. That was Professor Tandler, and he was a fine, lovable old soul, and I state that very positively. But the best men and the best women may have fine objectives and fine ends in view, and completely forget the methods by means of which those particular ends or objectives are to be reached. This is very apropos at the present time, because the proposal has been made right here in the State of Wisconsin, and through the Wagner Health Bill of 1939, to socialize medicine in America. If we give all powers over to the control of either the State of Wisconsin's politicians or the politicians in Washington, D. C.—I care not whether they happen to be Socialists, Republicans, or Democrats, all politicians are alike—they will attempt to self-perpetuate by plunder, and, unless they are held in check, power becomes poison. It grows and accumulates until, finally, it crushes the individual. That is exactly what it did in Vienna.

Professor Tandler said, "We have these sick poor people under our control." And in a city of over two million, there were 450,000 individuals who came under the control of Professor Tandler in the socialized medical scheme of Vienna.

Some of the large apartment houses they built there, like the George Washingtonhoff and the Karl Marxhoff, would take up four or five city blocks here in the city of Milwaukee. They were seven or eight stories high, and as many as 5,000 to 8,000 people lived in those tremendous fortresses. Food, clothing, shelter, and medical care were given entirely by the state.

Austria, at that time, was like a large monster with a tremendous head and no body. There was very little out in the rural districts of Austria. Vienna drained it all, and the socialistic politicians within Vienna drained it directly into their coffers for their

own particular ends. They drained Vienna dry, until Vienna was anemic; and then Austria fell.

Unless you had an opportunity to go through such institutions with a man with high ideals, like Professor Tandler, you would likely be misled, because there is no question about the sincerity of the man who was leading socialized medicine in Vienna. He felt he was doing the right thing, and he felt it was the only solution. But as soon as you talked to his assistants, a different story was heard. You found that the individuals who were harbored in these large institutions at the expense of the state were allowed to live there *as long as they voted the political ticket in power.* If they did not they were put out summarily.

In other words, the method of the politician has nothing to do with race, creed, or color, or any other type of relationship. As soon as individuals get into complete executive and administrative control over the lives of others, with no check rein, no balances, no restraints, they all act alike. That is a fundamental trait in human nature.

"Not From Poor Motives . . . "

There are many, right in the practice of medicine at the present time, who would like to sell out medicine from within. I will not say they do it from the standpoint of poor motives. Unquestionably, their motives are sincere, and their ends and objectives are high as far as their ideals are concerned. It matters not whether the individual is sincere or whether he is not, medicine will be led astray by those from within, if good judgment, past experience and human nature are ignored. Now it is hard work to think, and it is easy to follow a leader; and it is easy to follow a false prophet. We have plenty of them in politics, medicine, economics, and sociology. The quacks are not all confined to medicine. Many think that because a man happens to utter a statement in regard to sociology, that the average family doctor is not familiar with the subject and that it is something he cannot understand.

So it is with individuals like Sigerist, professor of history of medicine, Johns Hopkins University, and Hugh Cabot, formerly dean of the medical school at the University of Michigan, and now in Boston forming a White Cross unit. Many of you have read his articles recently in regard to how fine and how great and how much more efficient men are if they act *in the mass than if they act singly.* There was never a more false, spurious philosophy preached to the American people or to American medicine than such a thing, because even in the army it is known that men without self-discipline in the mass are useless. It is the thinker, as an individual, who is worth while. It was Napoleon who said, "Men in the mob are nothing, but the trained individual man everything." You will find those sociologists, who are attempting to change our form of government, doing their utmost to bring discredit upon what they call the old-fashioned relationship of the doctor and his patient. They say that it is something of the past, that there is nothing in that particular type of relationship that needs to be retained, because the government can handle, by itself, the whole relationship by collecting a compulsory sickness tax or a compulsory health insurance. I do not think there was ever a more false implication made to improve the health and human welfare than the so-called compulsory health insurance proposal in the 1939 health program of Wagner. The government would collect the taxes in regard to sickness care. The doctor would be definitely allocated under the control of individuals outside of his relationship to the patient, and there would be a false relationship to which we are not accustomed here in America, and about which we know very little.

"The Irishmen in the Third Ward . . . Are Healthier . . . "

If you think that the Irishmen down here in the third ward in Milwaukee, or the Norwegians down in Racine county are not a great deal healthier than those in Europe at the present time, then you have not kept up with the daily news.

I wonder how many of you right in this room—those of you who have been talking for socialized medicine and for group medicine, in imitating some foreign system,

either in France or Italy, or the panel system in England, or the KrenkenKasse system in Germany, or the system in Russia—would like to change the seats you now occupy at the present time, go abroad into those countries, and adopt the methods they are carrying on there. How would you like to transplant yourself, roots and all, from this particular fine city of Milwaukee, for instance, to any city in Europe?

The health in America has never been better than it has been during the last ten years, in spite of the depression. It is a peculiar thing that when everything else has gone down—finances, the promises of politicians, economic control, and social good will—when everything else has been in a panic and depression for ten years, one thing has been going up,—the health of the American people. Who gets credit for it,—the foreign isms abroad, those along the Atlantic seaboard that would like to implant still more foreign isms in this country, or the rank and file of the family doctors directly on the firing line with their patients? It has been that sacred relationship of doctor and patient that has elevated the health standards of this particular country, and we are giving at the same time due credit to the municipal and state health departments, as well as the United States Public Health Service.

"I Resent . . . "

But personally, I resent very deeply, as I resented here in Milwaukee two years ago, a representative of the United States Public Health Service who appeared before the Women's Club and gave those women the impression that if it were not for the United States Public Health Service, and other state health departments, we would not have the great health we find in the American people; furthermore, that the dominant concern and the source from which the health of the American people flows is from some tax-supported governmental health agency. There was never, again, a more false, spurious philosophy spread out. And when those club women of Milwaukee left that room, if you asked them for their vote at that time as to who should control their health, they very gullibly would have voted for state medicine, and there was not any agent of that service who had entered their lives or ever had anything to do with them except in cleaning up the external environment.

It is that type of propaganda—and it is propaganda, and propaganda of the most vicious type—that undermines you and me and every individual here in America. I would like to state this, and state it in bold type: **Public health is just as strong as the individuals who compose that public. Public health is nothing more than the sum total of the personal health of the people and, primarily, it has nothing to do with the government. The government can collect taxes from now until doomsday, and it would never definitely improve, fundamentally, the health of those individuals. Why?**

"Let Us Think For a Moment . . . "

Let us think for just a moment: Suppose we were in the freshman class at the medical school right now and the question was asked, "What is health?" Everybody is using the word, particularly in certain branches of the government.

When that question was asked of this United States Public Health Service representative, he said, "We are cleaning up the water supply here in Milwaukee. The sewage disposal is being handled through this fine sewage disposal plant. We have inspectors of food and vegetables, ventilation, and inspectors to reduce smoke and noise."

Certainly, those are all fine things in the control of the external environment of man, and I do not wish to denounce any of these advances in mass medicine, *but absolutely to denounce the idea that our health is dependent solely upon our external environment.* That is misleading the public and misleading ourselves. Why?

Let us look at the nature of man for just a minute. Of what is man composed? He is composed of a physical body, a mind, and a spirit. Let us see how these work.

One of the best definitions of health I have ever found is one by Bauer and Hull, and it is as follows: "Health is an emotional feeling of well-being in body, mind and spirit." Notice what it is. It is something immaterial, to begin with. You cannot get your

hands on it, smell, weigh, measure, or even tax it.

Let us see upon what health is dependent. Health is dependent upon the harmonious functioning of the body, mind and spirit. It is dependent upon a balanced functional relationship of the tissues and organs of the human body. It is dependent upon harmony of adjustment, both in the physical environment and the psychological environment of man. Do we seek health as an end in itself? No. Health is a means for constructive service in society.

No wonder those who want to drop bombs, dictate, control and shoot humanity do not know what health is, because health is a means to conservation. The physician is dominantly pledged to relieve suffering and conserve life, whether it happens to be on the battle field or in civil life. Unfortunately, in our medical schools these things have not been enphasized enough, as Dr. Ebaugh, professor of mental medicine at the University of Colorado, and who is our guest here tonight, knows only too well. He has been attempting over the last ten years to emphasize mental medicine more in the medical curriculum. How many of you, who are over 40 years of age, studied anything about mental medicine when you were in the medical school? What did you do as far as your study of the nature of man is concerned?

"You Pulled Apart a Dead, Stiff Cadaver . . . "

You went into the anatomical laboratory and pulled apart a dead, stiff cadaver, cold, chilled with loss of that warm, vibrant thing we call life. And if you don't think there is a fundamental difference between the man in life with his personality, and that carcass in death, then you have not stood at the bedside of a dying mother or a dying father, a sister or a brother, or anybody else close and dear to you. Some of our modern physicians, with all the instruments and armamentarium and help of the laboratory, are getting farther and farther away from the death bed. It is the intern, and others, who see life when it actually ebbs out, and those men in the private practice of medicine who are called to the bedside and have to give that particular service and comfort which depends upon the human relationship between patient and physician.

I am not denouncing scientific medicine, but I am denouncing the overemphasis of materialistic medicine and the forgetting of the nature of the individual and the personality under your jurisdiction.

As soon as you think that the practice of medicine is nothing but the building of hospitals, and the equipment of those hospitals with x-ray machines and various types of laboratory equipment, and other types of instruments you use for diagnosis, then you are selling out medicine from within. Why? Any governmental administrator could probably buy those things cheaper than you could, even though they might not appear on the tax rolls any cheaper. But the thing is, he would be able to follow through with those things in a jurisdictional sort of way and bring them under his control, if that is all there is to the practice of medicine. The state can build bigger and costlier hospitals than you.

The practice of medicine has a soul as well as a body, and the longer a man is in the practice of medicine, the longer he is around medical schools and the longer he is in close relationship with other humans, the more he realizes that these intangibles, these immaterial things that one cannot smell, weigh, taste or measure, become dominantly important. They have become dominantly important abroad at the present time. Some of those nations that collapsed so quickly just recently had sold out their souls before their bodies were controlled by an outside invader, and medicine in this country can only be defeated when the rank and file of physicians sell the soul of medicine.

"Let Me Illustrate . . . "

Let me illustrate exactly what I mean, because it may be a new expression to you coming from a scientist. I have spent my days in the dissecting room, and the longer you dissect and the longer you follow through the variations of bones and muscles and joints and nerves and blood vessels and the various other internal structures of the human body, the more you drive your head against a brick wall and realize you are not

following the real nature of man. All you can get is a certain amount of structural architecture there, but you have lost the thing that is most valuable at the bedside.

Those individuals abroad—in Austria particularly—what were they doing? They had been told by the government that through socialized medicine they would not have to worry about their health, that Tandler or the 1,200 physicians he had under his jurisdiction, would take care of it.

What could those men do? The only thing they could do, the way they were carrying through that practice, was to attempt to clean up the external environment around those apartment houses, and to give medicine by the bottle wherever they might be able to control belly aches in the mass. Yet with all the apparent purity of the external environment—it could be so pure as to be sterile—those individuals were fundamentally sick. They were sick in their minds. They were mentally laboring around at their places, but very few of the men had constructive work. They were sitting in the center of the courts and you could tell by their faces that they were a forlorn, mournful lot. And if you do not think the mind, in that state of imbalance, was the cause of the physical derangement that came subsequently, then you did not have the opportunity to see those people as they were going through dire distress.

The mind can control the body, and the soul, itself, when it is upset, when it is diseased, when it is warped, and when it is deformed; it can lead to just as much fundamental illness as though the invasion of an outside organism had struck that body. The imbalances of the mind and the rest of the physical imbalances that result are in reciprocal relationship. So those people were doomed because of the lives they were living at the instigation of the socialized state in Austria. They had lost self-reliance, they had no opportunity to exercise self-control, or self-restraint, or anything in regard to the control of their own lives. Why? Because their lives were entirely dominated from without by police force through governmental power. And if one thinks a government can support the people and the health of the people, then one has not followed those governments that have attempted to do that particular thing. It will be those individuals who are stronger in the majority, who are still self-reliant and still self-disciplined, who have the strongest health in their minds, bodies and spirits who will control the agencies of government. It will be these agencies of government that we must watch during the course of the next few years.

As Dr. Peterson of Sun Prairie, who is here, and the rest who happen to be close to the National Guard and Reserves now know, it will not be long before they will be on their way South for a year. We must be vigilant that the ideals of individual rights and responsibilities of American civil life, for which we are willing to fight, are not lost while these men are away to make the United States secure.

The majority of us, whether we happen to go back one generation or five generations, came over to this country to get away from the damnable intolerance, hatred, chaos, and tyranny that is abroad. Right in this room we have practically all races, creeds and colors, and we are bound together in American medicine right here in the State of Wisconsin. We want no isms, whether Naziism, Communism, Fascism, or anything else, to come over here and upset our Americanism. We do have a health record built up by American medicine, that has given this country in the last ten years the best health that 130 million people have ever seen. When everything else has been going to pot and ruin, the health of the American people has been on the incline. This is direct evidence of the social efficiency of the American medical profession.

"Yet, the Committee Ignored . . ."

Yet, the Interdepartmental Committee to Coordinate Health and Human Welfare—Josephine Roche's committee of 1938—when it met in Washington, ignored the American medical profession in the planning of their health program. There never was a more stacked committee to try to bring medicine into slavery and to bring the American people under the dominance of political control. Why?

Listen to this if you don't think cause and effect were tragically muddled, and if there isn't a place for straight thinking. In this particular report of which I speak, the claim is made that one-third of the people of the United States are ill fed, ill clothed, ill housed, and that probably more than this one-third are in poverty and despondency—because of what? Because they are sick. In other words, the reason our unemployed are now supported by the government in taxes, and the reason we have been going through a depression the last ten years, is that all of these people suddenly became sick in 1929. It wasn't due to hoggishness and greed in business; it wasn't due to the crackpot economist; and it wasn't due to the quack sociologist, nor to the racketeer in politics, nor to a misleading of public opinion by certain members of the press. No! It was due to the fact that the doctor failed, and all the people suddenly became sick.

How are you going to remedy it? Here is how Wagner is going to do it, as stated in his bill of 1939: You pay a compulsory sickness tax for the building of hospitals and medical care. The American people pay this particular tax, and then we will call in the doctors. The doctors will annihilate the sickness of these people, and we will have prosperity. The state claims people are poor because they are sick and ignores the fact that they do not have jobs. If the poor people had work many illnesses would disappear. Calling in a physician does not give poor people many things they need to get well, i.e., food, clothing, and shelter. In other words, there ought to be a blue sky law against individuals putting out a bill that has such quack philosophy, because the statement goes on the basis that, dominantly, the indigency of the people is due to the fact that they are sick.

Good health and sickness care will not be gained through the American Government, or by somebody sitting up in the city hall, or in the Federal Building, where you go to pay your income taxes or your city and county taxes. There is an honorable and just function for the tax collector. But how would you like to have those individuals be the ones who control your particular life and your health, alongside your bed, when you are ill? The American public has been fooled and hoodwinked by false philosophies of state, and not until we get back to straight thinking will we realize that the rights you and I have do not come from the state. In Germany, they come from Hitler; in Italy, Mussolini; in Russia, Stalin. Previously, in France the rights came from the deputies, but now they come from Hitler. In England, the rights of the individuals dominantly come from Parliament. But where do your rights and my rights come from? Do they come from some other individual? Are you dependent upon me for your inherent rights? No.

"It is Stamped Right on This Coin . . ."

According to the Constitution and according to the Declaration of Independence, we were all created free and equal, and we were endowed—get this, and get it straight—*by a Creator, with inalienable rights of life, liberty, and the pursuit of happiness.* It is stamped right on this coin, "In God We Trust," and I wonder how many of you individuals still think that. If you don't, why are you talking about Americanism? Because the only one your rights come from—they do not come from Washington, they do not come from Madison—is a Supreme Being. I might not be able to prove that Supreme Being to you in all scientific aspects, for the simple reason that science has nothing to do with ethics or philosophy or end causes, but, if an individual thinks, he will finally come to the conclusion that he is either going to worship the test tube or going to worship something his mother taught him at her knee, and it is up to him to make his choice. If you think these things the scientist can grow in his test tube, and weigh and measure, would make a fine, good god for you, all right, go on and worship him; but you will find out that the state will come along and say: "No, you are wrong. The state is god; it isn't that test tube. As long as we are god, we are going to control, so jump in line, for now you are going to goosestep." And away you go. Why? Because you have no rights.

It is a proposition of thinking these things through and, on the very same basis, *it is a*

proposition of acting on them. There are a good many Communists and Nazis and others in this country, who would like to change our form of government, talking about their rights of free speech and free press and free assembly, when they are actually tearing down the source of that particular freedom. And unless you *act* as a bulwark in society to help build up some of those things that have determined the faith of your fathers, you will not overcome these subversive influences. In the very first part of the Ordinance setting up this Northwest Territory, back in 1787, which gave us this fine territory of Minnesota, Wisconsin, Illinois, Indiana, and Ohio, it is stated that free men need education, morality and religious training. It has not been religion that has delicately poised the world on the peak of the roof of hell at the present time. It has been those human individuals who stated they were the supreme god, i.e., the state.

There is one statement in a book written by Dr. Hertzler that stands out in my mind vividly, because some of us probably have gone along rather indifferently in regard to some of these things. In this book called, "A Horse-and-Buggy Doctor," Hertzler said he came to the conclusion, after practicing medicine for a period of fifty years, that there was one reason he could see, purely on the basis of good policy, why a physician, particularly, and his patients, should believe in somebody higher than himself, and that was "to prevent him from making a damned fool out of himself in thinking he was God." There are probably a good many physicians who may come into that particular category if they begin to forget their particular relationships with their patients and think this particular relationship is not a sacred one.

Unless you possess something that is over and above the scientific stuff we can analyze, there is nothing sacred to you that the state will respect. If you reduce everything to the test tube and physical science the state will come along and reduce it still further to its own domination. This merely means, at the present time, with the great advances that have been made in medicine and the analyzing of those advances along with the scientific method that has been applied to control them, it is going to be very, very difficult to prevent the state from entering in, unless we realize that the patient has something more, over and above the bond of this mortal flesh, that we are able to handle. There is an esoteric something, when a doctor gives his service to his patient, that is over and above any other type of commercial commodity, something that cannot be weighed in the ordinary commercial scale,—and, unless we recognize this particular fact, then we are not being true to the fundamental idea that there is something over and above this physical diagnosis that we have.

"Many Things Make it Difficult Not to Sell Out..."

Now I want to state that there are many things which make it difficult not to sell out. There are individuals under economic relationships in the practice of medicine who find it very difficult at times to stick to the ethics of the Hippocratic oath. A good many individuals look upon that as old-fashioned and as something that was good enough for the days of long ago, in the past, but they do not need to carry it on themselves. That particular oath was given not only to protect medicine, itself, but to protect the patients, and as a consequence it is up to you to do the most you possibly can to see that that is not undermined with these young individuals when they first go out into the practice of medicine. We have to be true to that trust and follow it through consistently. It is going to mean the exercise of will power to "carry through" in spite of all the opposition which we will meet. I know that inside of the next week or so there probably will be a partial debate, right in this city, when the social service agencies meet, because the following through of medicine under strict governmental control is advocated. Just exactly how that group is going to react is something that only the future can tell, and it all depends on how the public will react to those oft repeated statements that socialized medicine is the thing for the individual. I think this is a time for militant medicine in regard to this relationship we know is so definitely fundamental, for if we destroy that particular relationship and sell out to the government, we have sold out

medicine. It is going to take will power to be militant.

By militant I do not mean headstrong and obstinate. Sympathetic leadership in medical education, public health, and sickness care must be supplied by the physician. Absolute willingness (1) to confer, (2) to be considerate of the opinions of others, and (3) to cooperate, is needed. Mutual faith, honesty, and good will are needed by the state, the public, industry, labor, agriculture, and the health professions (medicine, dentistry, pharmacy, nursing, and social service) in order to make needed progress in health and sickness care. *The conference room, however, must not be stacked in the future as it has been in the past.* Prior propaganda which undermines the confidence of the people in the American medical profession must stop. I am sure the American doctor will cooperate to the limit with any honest agency which is not seeking to destroy him and his belief in the sacredness of the individual human life.

"I Should Like to Conclude by Emphasizing . . ."

I should like to conclude by emphasizing that we follow through and fight against that group that is so definitely trying to bring state socialism into this country. The path by means of which it is intending to do this is by means of socialized medicine, exactly as was done in Europe. Socialized medicine was the first thing before Socialism and Communism came in. Look at history: 1864, definite, socialized health insurance laws were established in Russia and, in 1883, in Germany; 1918, the panel system came in England, in 1928–1934 in France, and, just prior to that by five years, in Italy. Notice how quickly we began, and with a change of philosophy of government, and a change in philosophy in regard to the way people should be ruled. In 1935 we had a very extensive Social Security Law; in 1938 the report of the Interdepartmental Committee to Coordinate Health and Human Welfare; in 1939, the Wagner Bill, *and the only reason it did not come up for consideration in 1940 is because we were in a debate as to our presidential and senatorial candidates.* In other words, it is based on politics. Unless those individuals of you who stay back as the rear guard, when the vanguard of military preparedness goes out of the community, come to the fore, something is apt to occur that will be sad for you and for me. It is going to require that restless flame to be passed right on to those who have the vigor to carry it on and also the courage expressed by Wilcox of Wisconsin to follow it through, for:

> One ship sails East and another West
> By the self-same wind that blows.
> It's the set of the sail, and not the gale
> That determines the way each goes.
>
> Like the waves of the sea are the waves of fate,
> As we voyage along through life.
> It's the set of each soul that decides the goal,
> And not the calm or the strife.

My faith, in spite of all the storm around us, is still in you and in the soul of medicine.

AUTOMOBILE AND MEDICAL EXPENDITURES IN FAMILY BUDGETS

"Recent studies by the United States Bureau of Labor Statistics indicate that the much exploited difficulties in the payment for medical care are due more to the increase of expenditures for other items in the family budget than for medical care itself," according to a recent issue of the Journal of the American Medical Association (Oct. 26, 1940, p. 1458).

"The Bureau of Labor statistics has recently set up a new basis for the index figures on costs and standards of living.[1] This required a detailed analysis of all recent budget studies. This analysis broke down the various items in the budget into such classes as food, clothing, fuel, house furnishings and miscellaneous. In this 'miscellaneous' item the greatest change in expenditures was found. The periods compared are 1917–1919 with 1934–1939. Expenditures for food and clothing made up a smaller percentage of the family budget in the later period, while the expenditure under 'miscellaneous' increased from 17 per cent of the total budget in 1917–1919 to 26.8 per cent in 1924–1936. The new index will be based on 1935–1939 and, when allowances are made for changes in the value of money and the exclusion of certain items which were previously counted as 'savings,' the percentage of expenditures for 'miscellaneous' in the average budget is raised from 23.7 for 1923–1925 to 26.9 in 1935–1939. When this 'miscellaneous' item is analyzed, expenditures for automobiles are found to have been practically negligible from 1917 to 1919, but now 'in combination automobile purchases and operation constitute almost one fifth of the new miscellaneous index.' At the same time the 'weight for medical care is less by one half.' During the last twenty years the purchase and care of automobiles seem to have had greater appeal than the desire for additional medical service. No doubt improved health has also lessened somewhat the need for more medical service."

[1] The Bureau of Labor Statistics' New Index of Cost of Living, Monthly Labor Review 51: 367 (Aug.) 1940.

What Confronts America and the Western Hemisphere Today*

By RALPH M. IMMELL
Brigadier General, Wisconsin National Guard, The Adjutant General
Madison

Ladies and Gentlemen:

I HARDLY know how to begin today, for I agree with the present Chief-of-Staff of the Army, General George Marshall, that one cannot play poker successfully with somebody watching over his shoulder and reading his hand.

When I observed the time that had been allotted to me, I felt perhaps I was expected to be brief, and I felt further, in view of the situation here in America and in the world, that probably I ought to be brief.

I should like, in the beginning, to take this occasion to thank the medical world of Wisconsin as a whole for the fine cooperation we have always received here in Wisconsin so far as our National Guard is concerned. For twenty years, we have had splendid cooperation from Marquette University, under the leadership of Dean Eben Carey. We have also had from the University of Wisconsin Medical School full support and cooperation in everything we undertook. Whether it was in the matter of securing excellent medical personnel, whether it was pioneering in studies in the field of syphilology, or whether it was in the more concrete, practical world of laying down health measures during the late Second Army maneuvers, we have always known that Col. Lorenz, Col. Bleckwenn, Dr. Middleton, and their associates, could be relied upon to give us the finest kind of cooperation. Then, too, your State Medical Board has given us excellent support.

I think it is very interesting to know that in the Second Army maneuvers, just concluded, the incidence of venereal infection occurring at Camp McCoy and Camp Williams amounted to only four cases out of some 63,000 young men who were concentrated in that area. That compares in such a favorable way with the other army maneuvers in the matter of incidence of these social diseases that it almost borders on the supernatural. It has long been the belief that if this incidence did not exceed 100 per 1,000, or more recently, 30.5 per 1,000, remarkable progress was being made. But here in Wisconsin, due to the fine cooperation and work of the State Board of Health in conjunction with the military authorities, only four acute cases developed during the maneuver. I think that is an indication of the very acute consciousness Wisconsin and its medical world have with respect to the social side of medicine.

"My Subject . . . Grips the Imagination"

My subject, "What Confronts America and the Western Hemisphere Today," is one, of course, that grips the imagination of every thinking American. Some five or six years ago I began to make public addresses throughout Wisconsin and our neighboring states, outlining what I believed was about to occur in the world. In fact, I then stated that from a study of geography, the location of the natural resources of the world, and the distribution of humanity in these lands of the world in relation to climate, one could tell definitely what was going to happen in the world; that he could tell where it was going to happen, and the only thing lacking was the time factor. Now, the time factor has been supplied by the leaders of the totalitarian states in the other hemisphere.

In 1937 I stated that a general European war would come not later than the fall of 1939, and I gave at that time to many of you who heard those talks the reason it would occur at that time, and not earlier. The reason given at that time was that those who wished to make war had not completed their preparations; those who wished to avoid

* Address presented at the 99th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September 20, 1940.

war knew that the time factor was on their side, and hoped by delay they would be able to prepare themselves for the ordeal ahead.

Since the autumn of 1939, we have seen a score of nations in Europe ridden under by mechanized armies. As I stand talking here today, we see the last great European democracy facing its Armageddon. We know, here in America, that the hour has come when America must prepare to meet her destiny. We know, here in America now, that despite the fact that the leaders of these totalitarian states intensely dislike each other and intensely suspect each other's purposes, they are united on one common thesis, and that is, that by armed might, by coordinated and concerted action they must interrupt and overturn the economy of the world.

We, who live here in the Western Hemisphere, say, "Ah! Yes, but that is something that concerns only the Eastern Hemisphere. That is something that somehow is very remote from us here in America." But we forget that the work of the mind and hand of man, as a result of 150 years of continuous education, as a result of 100 years of continuous research in every field, has continually shrunk the size of this globe, until the distances from Rome to Paris, Paris to London, Berlin to Moscow, and from Berlin to Wisconsin, are not nearly as great as the distance from Rome to England when Caesar massed his 800 barges off the French coast and made his invasion of England during the great height of his career as a conqueror and a Roman emperor.

"When a Crime is Committed . . . "

In the French police system, when a crime is committed, they say, "*Cherchez la femme*" —find the woman. So, too, must we find in the wars that are raging and the wars in the offing, the cause of these conflagrations. Today, without employing a map, but by briefly sketching over our economic history, I think I can bring you right down to date in short order.

We have passed through three great economic eras. In my avocation, the military, we have classified those eras as: The era of the farmer war, the era of the war of conquest, and the era of the commercial war.

Era of the farmer wars.—If you go back in your history to about the time of the coming of the Christian era, you will remember that just prior to that time the histories were filled with accounts of the great tribes that wandered out from the Near East, the Far East, and the unknown areas of the continent bringing their baggage with them, their chattel, their horses, their children, fighting, conquering, and, unlike wars since that time, remaining. That period, we call the period of farmer wars, because they came, they conquered, and they took over the ownership of the soil and attached themselves to it.

What is the reason those early people migrated? What put them on the highways looking for new lands that would support them? Either a harsh cycle in nature or unwise agricultural practices, such as we have had here in America, made it impossible for them longer to support themselves on a land that had been theirs since time immemorial. So they picked up, bag and baggage, and moved into Europe near the sea, where they would be assured of the mean average rainfall necessary to their agriculture, and where the low lands insured them that neither drop, sheet, nor bench erosion had seen the rich top soil destroyed. We haven't had any farmer wars in the world since those days, except when we came over and discovered this continent and took it away from the native Indian. We might have had farmer wars again in 1929 if we hadn't had the democratic form of government. With the process of government created in 1776, using our collective taxing powers, we could, to use a blunt word, "bribe" people to remain on the soils that were theirs and work out their salvation. If we had been a conglomeration of small nations, such as Europe had in that early day, our children's children, 500 or 1,000 years from now, would be reading about the period when these hungry tribes came out from the Dakotas, Wyoming and Nebraska, barging back into the green valley of the Mississippi, fighting, conquering, and remaining. But because of mass education, because of the mass voice in government, and because of the continuity in government and the fact

that we are one great people, we avoided all of that here in America.

Era of the wars of conquest.—Let us go back to those early farmer wars, after the tribes—the Goth, the Visigoth, the Gaul and the Hun—had moved into Europe and set up their little tribal states and began to prosper. Still mindful of the fear of famine, and still coveting luxuries that mankind will always covet, the leader of each separate tribal state looked over the mountain or across the river into the next thriving little state and said, "Boys, there is a fine community over yonder. Let's go over and whip them. Let's steal their cattle. Let's hold our swords at their throat and take from them these necessities of life. Let's enslave their young men. Let's demand tribute of them every year, and we will live free of the fear of starvation, and we will have these luxuries to which we as a superior people are entitled." So they went over and conquered that first little fellow—and as the Bible says, "It was good," and they moved on to the next, and the next, and the next.

Here you enter that period of great empires beginning, let us say—not chronologically—with the Holy Roman Empire. There was the Byzantine Empire and the Saracenic Empire that came up out of Mecca. Clovis, Charlemagne, Genghis Khan in the 12th and 13th centuries, Gustavus Adolphus, Napoleon,—each in his turn fashioned an empire. All roads led to Rome, or they led to Paris, or they led to Stockholm, or London, or Mecca—depending on the century; but the pattern was always the same. Living in a world with an economy of scarcity, they felt it was necessary for them to take by force from the other fellow the things to which they felt they were entitled. So you have that long period of those great political jigsaw puzzles, people held together by the sword, different in race, different in religion, different in national aspirations, and different in destiny. It is called the long era of security by conquest. But that period, too, came to its close.

Era of commercial wars.—In 1787, not many centuries after Johannes Gutenberg invented the printing press, and the written word was made available to mankind, the mass of humanity was exposed to the process of education, and men began to think about the world in which they lived and began to solve the secrets of the soil and the secrets of the mine, and the secrets of mechanical power. Someone invented the power loom. So, in 1787, we see the end of the second great economic era, and the beginning of the third.

From 1787 to 1830, the basic principles of power became known to mankind. If you remember from your history, at that time the three great nations having access to the sea, and having unity, were Russia, England and France. Realizing that they were walking into a new economic era, they went on the seaways and highways of the world to acquire the natural wealth of the world and put their house in order for the new day.

We, in the meantime, in America, started this humble republic on our side of the ocean. If you will review your American history, you will remember we bought Alaska from Russia, we bought everything west of the Mississippi from Napoleon, and France; we defeated England and drove her out of the eastern United States; and Spain, in a state of political decline, was compelled to let go in Florida.

All this wasn't an accidental thing. When power came, bringing the dawn of the era of wars of commerce, these nations having unity and access to the sea were putting their house in order for the third great era. They were over here dividing the resources of this country. So we lived in that period, the era of security through wars of commerce, down to 1920.

The New Era

We have now passed into the fourth great economic period, but we are still playing the game according to the rules of the third.

If you will permit me to digress for the moment, you will recall when England, France and Russia went out and put their house in order, there was no German Empire, there was no Austria–Hungarian Empire, or Italian Empire. They were united as empires and kingdoms between 1860 and 1870. They came on the scene after the party had been held and the resources of the world divided.

I remember, back in 1917, we used to curse the Kaiser and say he caused the war. I know now the Kaiser didn't cause the war. He merely determined when it started. The men who caused the war—in fact all wars in the third great economic era—were the men who brought power into the world, and moved us out of one economic era into a new one. The foundation for the World War of 1914 was laid in 1870 with the political revolution creating three new world powers. When these late arrivals failed to gain their ends around the diplomatic table, they took up the sword some forty-four years later.

The World War of today did not begin last September. It, too, began in 1870, and this is one more campaign in the war that had its armistice, and not its conclusion or economic answer, on November 11, 1918. Those are the essential facts.

If anyone here doubts that we have walked in on a new economic era, I merely invite his or her attention to the fact that, during the past seventy-five years, for the first time in human history, we have solved the problem of production in this world. Eight per cent of the farmers of America, I am told by good authority, using the agricultural knowledge now at hand could double our present agricultural output, but we have such a tremendous agricultural output now that we are starving in the middle of it. No one here believes for a moment that with every throttle of American industry opened wide, with proper auxiliaries to complement existing plants, America couldn't almost furnish the industrial needs of the world, and yet we have such a volume of industrial production now that we know not how to consume it.

These things don't happen over night. I remember we used to blame certain Presidents for causing the depression, and still do. We blame others for causing a recession, but the mere fact is that we have walked into a new era.

Let us look for the first symptoms of this new era—*this new economic disease with its crisis called "war."* Go back in your English language seventy-five years, or into our own economy. There was a time when we didn't have such a thing as a traveling man—a drummer—but when the inventories began to grow in the granary on the farm, on the merchant's shelf in the city, and in the warehouse of the industrialist, we invented that fellow to go out and induce people to buy, to move those inventories. That worked for a little while, but as the assembly lines gathered momentum, and as men cracked open more secrets of the soil, those inventories began to grow again. So we invented a word. We went to the Latin and found a root for a brand new word. We took, I believe, the Latin word "credo" and manufactured the word "credit." We had a good word for credit, but it had a bad odor to it. That word was "debt." I am speaking now of consumer's credit. Debt conjured up pictures of the debtor's jail, process servers and lawyers. We got a new word, and the merchant sent out a letter asking, "Why don't you use your credit? Your credit is good." A very flattering piece of mail. What he was saying to us was, "Because we have to move these growing inventories; because to do this we must get you to pledge tomorrow's income for today's purposes, we have decided to let you go in debt to us for a limited amount, and a limited time." Again we expanded our sales and our consuming power, but that wasn't sufficient.

When automobiles began to come off the factory lines at the rate of 5,000 a day; when the tremendous productive powers of American genius, American industry, and the American farmer really began to assert themselves, we invented all sorts of devious devices to promote sales, and among these we invented installment buying. Now we bought our house on the installment plan, and we bought our car and our insurance on the installment plan. We pledged every bit of income as far in the future as we could see. When there was no more future income we could see, no new source of prospective income we could tap, and ever-increasing production continued to roll off the assembly line, the thing came to a stop. It came to a dead stop. We primed the pump. We have done everything human ingenuity could think of in order to put life back in the heart of industry and the heart

of agriculture, but somehow the patient just doesn't seem to get out of the hospital.

The Remedy and Prognosis

Why does the patient remain ill? Why? Because the sick man requires a major operation. A tonic isn't enough. We have slipped into a new economic era. We have solved the age-old fight to produce both necessities and luxuries in adequate quantity. *We must now match that new-found power with consuming powers sufficient for the day's demands.* This is the first big task that confronts America. To go forward, we must make the American way work. The search for security had been won. The prayer for plenty had been answered. Yet these mad men who came to power in the world remained blind to the dawn of a new economic era and have plunged the world into a needless war for commercial plunder—a war in which if America is involved and beaten, or in which America is unwilling to insulate and isolate the American way on which to build the new economy of plenty, we may see the destruction of two thousand years of human progress.

Over in Europe we have a lot of these nations who have been thinking about these great agricultural and industrial resources of America—about the necessity of getting the control of them into their hands in order to work out their own economic salvation. Bad men don't make these situations, but bad situations make these men, and the Hitlers and the Stalins and Mussolinis of this world are the direct product you always find on the short-rationed side in human history whenever world economy is undergoing some great chaotic, economic change.

To come back to my subject of what confronts America, let us remember this: Here in America we have 130 million people, roughly one-fourteenth of the population of the world, and that one-fourteenth of the population has within its control and within its boundaries one-half of the wealth of the world. You can use any yardstick you wish by which to measure that wealth, but in iron resources, in oil, in coal, in agricultural resources, in cotton and wool; in fact, every commodity you can mention, except a limited number of the so-called white metals, here in America one-fourteenth of the population of the world has within its boundaries one-half of the wealth of the world.

Since these men in Europe have started out to acquire from the other fellow these things they think it takes to make them masters of their own countries and masters of the world, I think it goes without much argument that at the conclusion of their military enterprises in Europe their next step will be to employ their great armaments in the Western Hemisphere. When that will occur, no man knows, but I say to you today that if England goes down, you can expect to see a new alignment in Europe, with the Latin nations looking after the infiltration and penetration of the Southern continent, with the Germanic races reaching out and asserting their pressure along the line of Scotland, Iceland, Greenland, and the Canadian northeast, and with the great bear that walks like a man in Russia, re-asserting his claims to our outpost of the North.

Already, the Russian papers speak of that illegal deal made by a decadent leader of a dying dynasty, when the Czar of the Russias sold Alaska to the United States. And if you do not believe that this country would find itself in a most embarrassing situation, picture a situation in which she is compelled to operate on three such geographically divergent fronts.

What I have said here today I have said on my own authority, and not on anybody else's authority. This is my own view, and not the view of any one with whom I may have been in contact.

These conquerors of today, just like the conquerors of all times, will never go out of the conquering business until they are dead, overthrown, or ultimately defeated. Read your history. Whether it has been Darius, Xerxes, Genghis Khan, Napoleon, Gustavus Adolphus, Peter the Great—any, or all of them—they have all come to the end of their careers still engaged in conquest. When Alexander had reached the age, I believe, of twenty-six, he wept because there were no more worlds to conquer. Since his day, the great Western Hemisphere was discovered —the granary of the world, the bank that holds the riches of the world. It must be a

great temptation to any man who sits on top of a lofty mountain, wondering if God Almighty doesn't have him by the hand, and wondering if he is not the one man destiny has chosen to encircle the world by conquest and become its master.

"Doctors in Wisconsin . . . Will Be Called On . . ."

You who are doctors here in Wisconsin, will shortly be called on to begin playing some part in the first steps America takes to prepare herself, to look after, not English business or French business, but to look after the business of this country, and to make sure that when the job is finally mastered here at home, no conqueror or no combination of conquerors will dare to undertake the task of extending his or their sphere of influence into those portions of the Western Hemisphere that America says we preempt for ourselves, since they are necessary to the defense of America and to protect American security. I know you will gladly give what is necessary of your time, your training, and your experience.

I know, in these days with political campaigns on, it is sometimes hard for us to see our way through. When you remember, in the campaign being waged by two rival candidates for President, they are agreed upon one thing, that here in America the hour has come when we must buckle on our armor; that the time is passed when we can close our eyes to the situation in another hemisphere; that the time has passed when we can be so naive as to believe that the machinations and maneuvers of Russia, Italy, Germany and Japan are separate and are not a connected, preconceived plan of campaign to again divide the resources of the world, it is very simple for us here in this country to make up our minds, even during a partisan campaign, where the right road runs to American security.

If we believe we have something here that we have a right to keep, and we ought to keep, then let's pay the price and keep it. If we don't believe that, then we ought to begin studying the manuals of the other fellow and the experience of the people who have permitted themselves to be overrun.

Industrial Health as it Relates to National Preparedness*

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IN A recent editorial in the *Journal of the American Medical Association* the thesis was developed that:

"Modern warfare depends on industrial production. The skilled worker becomes of importance equal to that of the man under arms; his indispensability grows as it becomes difficult or impossible to replace him. Shortages are said to exist now in certain classifications of experienced craftsmen. The problem then is not solely one of educating new workers, since long periods of apprenticeship are necessary to acquire dependable ability. More important is the task of guarding the existing supply of competent and skilled workers against preventable disability. Fortunately, the medical and allied professions find themselves in better position now than in 1917 to combat causes of lost time in industry. Lessons learned in the last war about preventive industrial medicine, industrial hygiene engineering and industrial nursing have not been forgotten. Since that time technics for control over industrially induced accident or sickness have developed steadily. Trained personnel and special facilities for investigation and prevention are available in nearly all the industrial states, maintained by governmental agencies or by private industrial or insurance organizations and universities. They constitute the immediately available machinery for investigation of new occupational hazards and improved control over old ones.

"Private industry also has equipped itself to protect its workers through the maintenance of medical departments. Physicians in charge of such departments are far more numerous now than formerly. They are a body of specialists in industrial practice whose equipment has progressed far beyond the relative immaturity of twenty-five years ago. In their responsible positions they act as sources of information and training for additional medical recruits. Already arrangements have been made to place at the disposal of the government the knowledge and special ability of these industrial physicians and hygienists.

* Presented at the 99th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September 20, 1940.

"Similarly the general medical profession is in a much better state of organization for specific assignments in industrial health than previously. The Council on Industrial Health has acquired information about the activities of all major medical agencies interested in the health of workers. It has conducted a census of physicians who confine their interest or give special attention to industry throughout the nation. It has investigated available facilities for industrial medical training and has arrived at conclusions about what needs to be taught both before and after graduation. At the recommendation of the Council on Industrial Health, cooperating committees in the state medical societies have been formed in the industrial areas and in a great many counties. These organized units, augmented as necessary, are available for investigations on the nature and prevalence of industrial hazards, the correlation of all local resources for control of industrial absenteeism, and the utilization of channels for professional training as well as health education for the worker. Loss of working time by skilled and indispensable workers, no matter what the cause, must be classed in war time as casualties which require mobilization of medical resources for competent handling just as do those which occur in the field. The medical profession needs to be well prepared to shoulder this special responsibility."

The United States Public Health Service has in operation machinery which it has developed for the prosecution of a program of industrial hygiene for industrial workers engaged in national defense. This program will be carried out in cooperation with other federal and state agencies concerned with industrial health problems, with nonofficial agencies, and with industry and organized labor. The thirty-one units of industrial hygiene in state and local health departments, developed and partially subsidized under the Social Security Act, will play a prominent role in the program. These units are being encouraged and assisted in the development of programs for the conservation of manpower in industry which will be of practical value in each locality. The Public Health Service has also developed a program in cooperation with the United States Department of Labor whereby many of the voluntary safety engineers throughout the country will assist in the control of health hazards. The Secretary of Labor has recently appointed a committee of twenty-four prominent safety promotion authorities to form a National Committee for the Conservation of Manpower in Defense Industries. This committee has developed a plan, the essence of which is to bring to industries operating on government contracts, particularly smaller industrial units, the expertness and efficiency in accident control exercised by the country's largest and best managed industries. This will be done through the voluntary services of safety experts from all parts of the country. The committee has divided the country into eight regions. The Division on Industrial Hygiene of the United States Public Health Service has tentatively agreed to the following plan: Each regional director of the Labor Department's national committee has been given a list of the state industrial hygiene units in his area. Should any one of the voluntary safety experts encounter occupational disease hazards in the course of his investigations, he will arrange for the plant management to ask for the services of the particular industrial hygiene unit involved. The national committee of safety experts will have entree to all plants engaged on government contracts.

Some of the activities to be carried out by the personnel of the industrial hygiene division of the service and the various state units and other agencies, among them units of the American Medical Association, will deal with the following subjects:

1. Location of new plants and advice on construction and renovation of plants in the interests of safety and health.
2. Investigation and control of specific industrial hazards.
3. Study of fatigue in relation to the defense program.
4. Absorption of handicapped persons into industry.
5. Survey of present health services in industry.
6. Development of a program for physical examination and medical services by industry.
7. Classification and training of additional personnel.
8. Classification of educational institutions for the training of personnel and existing laboratories which could investigate hazardous materials to be employed in defense industries.
9. The preparation and dissemination of information on various toxic materials and processes for the practical protection and health of workers.
10. The promotion of measures for the control of syphilis, tuberculosis and other communicable diseases among industrial workers.

The Committee on Medical Preparedness of the American Medical Association was formed to provide information about medical personnel and to take the necessary steps for prompt availability in any situation demanded by the national defense. One of its responsibilities, therefore, is to determine present resources for adequate medical supervision of industrial workers. The Committee on Medical Preparedness is made up of members from each of the army corps areas. It works in close cooperation with the Surgeons General of the army and navy medical corps and the Surgeon General of the United States Public Health Service. In each of the state medical associations, a committee on medical preparedness has been formed and it is intended that similar committees be organized in county or district medical societies.

The Council on Industrial Health will assist the Committee on Medical Preparedness of the American Medical Association. It is planned that the committees on industrial health in the state and county medical societies should promptly establish a similar relationship with the committees on medical preparedness in their own parent organizations. A working idea of the necessity for close cooperative activity both up and down the line in medical organization is demonstrated in the accompanying schematic drawing. Perhaps the quickest insight into the kind of special activity which may be assigned to committees on industrial health in organized medical societies is reflected in the program of the Council on Industrial Health. At a recent meeting, it was decided that the Council could be most helpful to the Committee on Medical Preparedness of the American Medical Association by vigorously supporting the following program:

1. To identify all physicians now qualified to perform various aspects of industrial medical service. (This activity of the Medical Preparedness Committee is developing rapidly. Early indications are that a list of 5,000 physicians who have some participation in industrial medical activity will be obtained.)
2. To inquire of each industrial physician whose name is derived from this census of physicians, his qualifications and experience and the nature of the industrial medical facilities at his com-

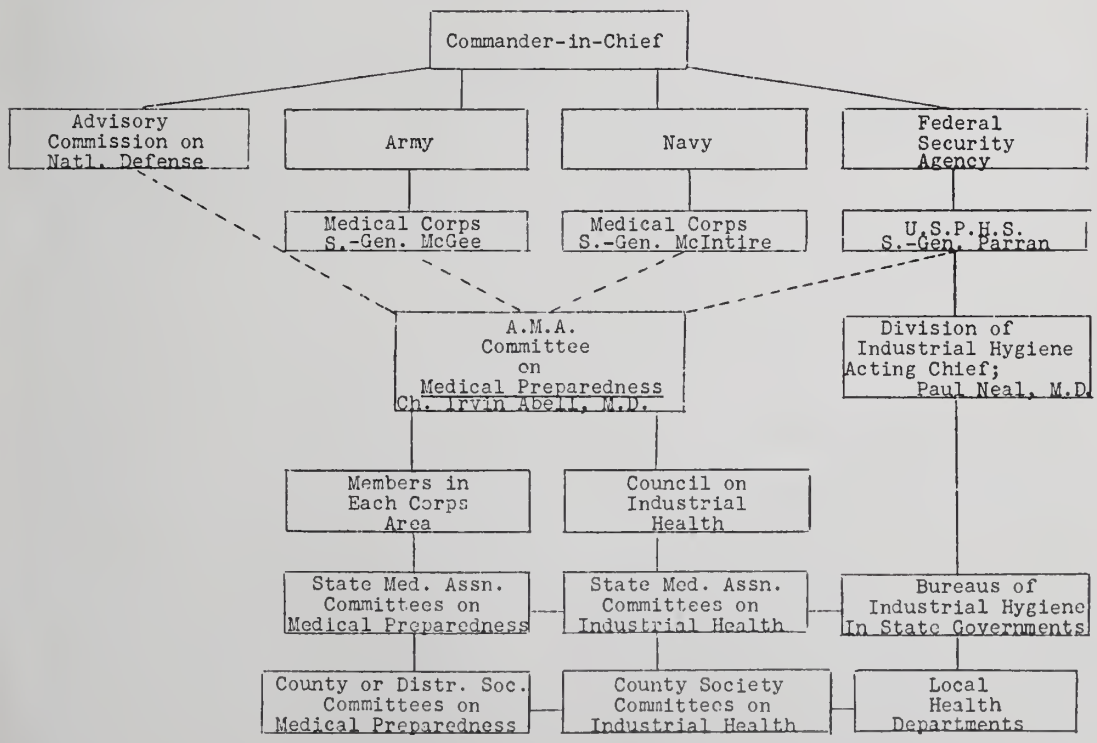

Diagram of organization of medical services for national defense.

mand. (A questionnaire has been developed based on one used formerly by the Council.)

3. To acquire and publish information on the nature, location and control of dangerous industrial health exposures. (The publications program of the Council contains definite proposals along these lines.)
4. To improve and augment the organization of cooperating committees on industrial health in the state and county medical societies, and to develop a program of field activity to the end that—
   a. Agencies can readily be formed in industrial areas with knowledge and authority to determine where industrial medical service is needed and to arrange that the service be supplied.
   b. Proper coordination exist between all independent agencies having an interest in industrial health, notably physicians in general and special practice, nurses, hygienists, and other technical experts.
   c. Proper correlation exist of all activities bearing on the problem of industrial physical examinations.
5. To assist in the development of intensive training courses in industrial health methods.
6. To insist that an assignment in industrial practice be regarded as equal in importance and dignity to a medical assignment with the combat forces.

Dr. Thomas Parran, Surgeon General of the United States Public Health Service, recently said that the problem which concerns each of us today is what we can do to contribute to the safety of our country. The whole task of national defense is different from what it was twenty-five years ago. The concept of a total war necessitates the concept of a total defense. National strength can be built up only by adequate application of all the sciences to the provision of armaments, munitions and supplies, food and manpower. Our job as physicians is manpower.

Perinephric Abscess*

Review of Twenty-One Cases, With Special Reference to an Anaerobic Infection

By B. B. MADISON, M. D.
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Review of the Literature

Perinephritis is one of the most common conditions encountered by the kidney surgeon and pathologist, but suppuration in the perinephric space is relatively rare. Semple[1] reports the incidence of perinephric abscess in hospital practice as 1 per 1,000 admissions among adults and 1 per 2,000 among children. Perinephric abscesses may be classified, according to Fowler and Dorman, as follows:

(1) Those having origin in destructive lesions of the kidney (pyonephrosis, nephrolithiasis, tuberculosis and trauma).

(2) Those of metastatic origin in which there is a history of a remote focus of infection (boil, carbuncle, paronychia and upper respiratory tract infection).

(3) Those of rarer incidence caused by direct extension from neighboring organs.

Abscesses secondary to definite renal lesions are usually recognized because of a history related to the urinary tract. In a review of 106 cases at the Mayo Clinic over a ten year period Hunt found 44.3 per cent to be of this type, while 55.7 per cent were metastatic in origin. It is in this latter group that the diagnosis is sometimes difficult.

Dr. Edwin Beer,[2] in a survey of forty-three cases of coccal infections of the kidney, found thirty-two or 74.4 per cent in which there were cortical abscesses with an associated perinephritis and perinephric abscess. Staphylococcus aureus was found to be the offending organism in thirty-eight cases. In a study of the blood cultures, he found seven staphylococcemias out of a total of twenty-six studied in this manner.

Analysis of Twenty-One Cases

A REVIEW of twenty-one cases of perinephric abscess is presented, nine in women and twelve in men. In ten, the abscess occurred on the right side and in ten on the left; in one case the condition was bilateral. The youngest patient was 11 years of age, and the oldest 83 years of age; the average age was 46.4 years.

In reviewing the histories in these cases, a characteristic finding was a duration of symptoms from three weeks to two months. Symptoms and findings of pain in the back, sepsis, and tenderness in the costovertebral angle were consistent. A variable tumor mass or bulging in the flank was seen only in the advanced cases. The leukocyte count varied from 8,950 to 34,150, the average count being 18,600. The histories listed previous upper respiratory tract infection in

* Paper based on work done by Dr. Madison while he was on the urological service of the Milwaukee County Hospital, Milwaukee.

three cases, furuncles in four, abscess of the foot in one, and pulmonary tuberculosis in two. Analysis of the perinephric pus revealed staphylococci in fourteen cases (66.6 per cent), tubercle bacilli in two, E. coli in one, Cl. welchii in one. In three the organism was undetermined. It is interesting to note that in six cases (28.5 per cent), there was an associated diabetes mellitus.

This series does not include injuries of the urinary tract, but eleven of the patients had definite destructive lesions of the kidney which were proven on x-ray examination, at surgery or at necropsy. Twelve had pus and bacteria in the urine; in nine, tests for these elements were negative. Sixteen of the patients were given x-ray examinations. In thirteen there was a loss of the psoas muscle line. This was the most consistent finding.

Sixteen of the patients were operated on. In fourteen, only incision and drainage of the perinephric space were necessary. Nephrostomy was performed in one and secondary nephrectomy in one. Aspiration was done in one case of bilateral renal tuberculosis and pulmonary tuberculosis. Of the sixteen patients treated surgically, one died. This patient had renal tuberculosis.

Autopsy was performed in four patients. None of them were ever on the urological service and the urologic condition was undiagnosed until autopsy.

The following case is presented in more detail, because the causative organism is unique.

Case Report

H. M., a 59 year old white man, entered the Milwaukee County Hospital on May 18, 1939, with complaints of pain in the right flank, fever, weakness and malaise of two weeks duration. He was feeling well until two weeks prior to his admission to the hospital. The condition began insidiously with weakness and dull pain in the right flank and back, associated with slight dysuria and frequency of urination. No other urinary complaints were noted. He had had no recent staphylococcic or upper respiratory tract infection. No history of any type of trauma was elicited.

Physical examination revealed a very well developed and fairly well nourished white male who did not appear acutely ill. The only finding was slight tenderness in the right flank and right costovertebral angle.

Urinalysis showed a hazy appearance, specific gravity of 1022, no albumin or sugar, and fifteen white blood cells per high power field, but no organisms could be demonstrated. The blood count and hemoglobin determination showed the following: hemoglobin, 12.5 grams (81 per cent); red blood cells, 3,890,000; color index, 1.0; white blood cells 20,600. Blood chemistry studies were normal. A cystoscopic examination and roentgen ray studies, including bilateral pyelography, revealed no abnormality.

The patient continued to have pain in the right lumbar region. The temperature was septic in type, ranging from 98 F. to 102.4 F. daily. On May 26, 1939, a slight bulging in the right flank was noted which was exquisitely tender. The pain became more severe and constant at this time, and a diagnosis of right perinephric abscess was made. A plain roentgenogram of the abdomen was taken. This appeared normal. There was no obliteration of the psoas line. Blood examination at this time revealed the white count to be 19,350. A differential blood count showed segmental forms 40 per cent, stab forms 50 per cent, small and large lymphocytes 8 per cent, endothelial cells 1 per cent, and eosinophils 1 per cent. The patient was strongly advised to have the abscess opened but refused.

Two days later consent for operation was obtained. A right lumbar incision was made over the point of maximum fluctuation. Upon dividing the abdominal muscles large blebs, brownish-black in color and filled with foul-smelling gas, were encountered. These were 2.5 to 4 cm. in diameter. When the perinephric space was opened, there was released a large amount of thin, watery, grayish, foul-smelling pus. Culture and animal inoculation of this demonstrated the organism to be Cl. welchii in pure culture. The patient was immediately placed on sulfanilamide and given 40,000 units of the combined anti-gas gangrene serum. The wound was continually irrigated with hydrogen peroxide solution. There was considerable discharge from the wound until June 7, 1939. On June 29, 1939, the wound was completely healed and the patient was up and about and feeling well. Urinalyses at this time revealed no abnormalities. He was discharged from the hospital the following day.

Gas Bacillus Infection

Gas bacillus infections occasionally occur as secondary invaders of wounds or as the result of trauma.

Review of literature.—The author's review of the literature has not revealed any record of perinephritis of anaerobic origin. Clute and Anglem[3] report two cases following cecostomy. Millar[4] reported 1,329 cases of gas gangrene in 25,272 surgical cases in the American Expeditionary Forces during the World War. Orr[5] reported three cases which were fatal following enterostomy. Bower[6] found anaerobes in 60 per cent of 155 cases of gangrenous appendi-

citis with spreading peritonitis. Gas gangrene has been seen to follow all types of surgical operations, including rupture of the liver.

It is a well known fact that Cl. welchii is a normal inhabitant of the intestine, where it grows in an alkaline medium, and these organisms are sometimes found in the stomach in achlorhydric conditions, such as carcinoma and pernicious anemia. While these organisms are in the gastrointestinal tract, no exotoxin is produced. I believe that the case described above was of the rarer type caused by an extension from a neighboring organ—the bowel or a rectrocecal appendix.

Radical treatment is indicated in gas bacillus infection. This consists of free excision and debridement of the affected area. Antitoxin should be administered as soon as the diagnosis is suspected, and should be repeated. Sulfanilamide has been shown to be of definite value in these cases. X-ray therapy may be efficacious.

Diagnosis of Perinephric Abscess

The diagnosis of perinephric abscess is made on the history of a staphylococcic infection, upper respiratory tract infection, systemic disease, symptoms of back pain, chills and fever, finding of tenderness at the costovertebral angle, leukocytosis, and the finding in a plain x-ray film of obscuration of the psoas muscle line with curvature of the spine away from the lesion. Beer[7] called attention to these x-ray findings in 1928.

Pyelography may be of value in showing renal displacement. Recently lateral pyelograms have been an aid in demonstrating anterior displacement of the kidney. In consideration of a differential diagnosis, long-continued fevers such as typhoid, tuberculosis, undulant fever, dysentery and endocarditis must be kept in mind. Abscesses of the appendiceal and subdiaphragmatic type may be confusing. A retroperitoneal sarcoma will produce the same pyelographic findings. Davis[8] recently reported that he operated on a patient with a sacculated aneurysm of the aorta for perinephric abscess.

A review of twenty-one cases of perinephric abscess has been presented and special reference made to one case of the disease caused by an anaerobic organism. In this series the condition showed no affinity as to sex or side involved. Metastatic and destructive lesions were about equal in number. In most cases, the condition, when diagnosed, responds well to simple incision and drainage. When there is extensive destruction of the kidney, nephrectomy, partial nephrectomy, or nephrostomy may be required. When this is contemplated, the exact status of the other kidney must be carefully determined.

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REGISTRATION OF ALIENS

The Alien Registration Division of the U. S. Department of Justice, Washington, D. C., has requested *The Journal* to publicize the requirements of the Alien Registration Act, which went into effect August 27 as a phase of the national defense program. The Act requires all non-citizens 14 years of age and over to be registered and fingerprinted at registration post offices or in places that have been officially designated for registration. The alien can register and be fingerprinted in person only. The only non-citizens not required to report personally for registration and fingerprinting are alien children under 14 years of age; they are registered by their parents or guardians, but are not fingerprinted until they have reached their fourteenth birthday, at which time they register in person. **All aliens must register by December 26, 1940,** or face the penalties provided in the Alien Registration Act—a fine of $1,000 or six months' imprisonment, or both.

Aliens temporarily in this country—such as students, tourists, etc.—are subject to the Act as well as those of permanent residence. Aliens of temporary residence are required to report their addresses every three months, regardless of whether they change address.

Forms for registration and reporting of addresses are available at post offices.

The Cardiovascular System as Related to Surgical Risk

By W. T. CASPER, M. D.
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THE cardiovascular system has always been accorded first place in the surgeon's thoughts when considering the operative risk of his patients. Although this is probably due in part to our tendency to consider the heart as the most "vital" of the vital organs and to the fact that unexplained sudden deaths are so often erroneously attributed to failure of the cardiovascular system, we cannot deny that careful study and evaluation of it will often enable us to foresee and thus forestall catastrophe. Much has been written about this subject by cardiologists and by surgeons, and my purpose is not to add new information but rather to attempt to correlate the findings and opinions of others, and to condense them into a convenient form.

A careful, detailed history will often reveal information that will direct special attention to certain parts of the investigation. Thus, a story of previous unexplained chest pain immediately arouses suspicion of coronary heart disease, or a remote siege of scarlet fever suggests that myocardial impairment, otherwise obscure, may be present. A normally acting heart may bear the invisible scars of previous thyrotoxicosis. The danger of these defects is materially reduced by the knowledge that they exist.

After careful physical and electrocardiographic examinations have been made, the patient can be classified in one of the following divisions, and the degree of surgical risk determined on a basis of past experience and knowledge of the pathology involved.

Cardiac Arrhythmias

The cardiac irregularities vary widely in prognostic significance, so it is imperative that an accurate diagnosis be made. Among the lesser irregularities are sinus arrhythmia and the mild bradycardia often found in young athletes. However, a pulse rate under 60 beats a minute that does not increase on exercise must be regarded with suspicion as it may signify true heart block. Alternating ectopic beats which are not strong enough to reach the radial pulse may also, though rarely, present this picture.[1]

Ventricular extrasystole is of two types, extrinsic and intrinsic. The extrinsic type is usually right ventricular in origin and is often due to increased intra-abdominal pressure such as in the latter months of pregnancy. This type of ectopic beat is unimportant. An evaluation of the importance of the intrinsic type, which is most commonly due to toxic myocarditis or to myocardial embarrassment, depends upon clinical and electrocardiographic findings.[1] In a known case of myocarditis, the onset of ectopic beats denotes fatigue of the heart muscle.

Auricular fibrillation, probably the most common of the irregularities encountered by the surgeon, occupies an intermediate position in prognostic value. We should bear in mind that fibrillation is a symptom and not a diagnosis. It may be secondary to mitral stenosis, toxic myocarditis or myocardial degeneration, or may be a symptom of an acute infection. In the latter case it may be taken as a bad sign because it indicates failing heart muscle. In contrast to this, however, the fibrillation which is often seen in patients with thyrotoxicosis need cause little concern.[2]

If the operation is one of election, it is better to control the fibrillation with digitalis or quinidine, but emergency procedures need not be delayed for this purpose because the risk arising from this condition is not great.[3] The occurrence of auricular fibrillation while the patient is on the operating table should not be cause for alarm, as it usually ceases without causing trouble.[4]

The only arrhythmias which of themselves are important signs of grave prognosis are complete heart block and pulsus alternans.[4] None but the most urgent operations should be undertaken in the presence of these conditions, as they are signs of serious myo-

cardial damage. Sudden death often occurs during the convalescent period in patients with normal rhythm but with variation in force of the alternating pulse beats.[2]

Valvular Lesions of the Heart

With the exception of syphilitic heart lesions, the valvular defects do not of themselves add to surgical risk. The syphilitic heart is a "bad actor" and sudden death on the operating table is not infrequent in those so afflicted. This is probably due to the fact that the frequently accompanying syphilitic aortitis has an unfavorable effect upon the openings of the coronary arteries.[1]

Willius[5] states that great cardiac enlargement indicates cardiac disease of long standing and of a progressive nature and that cardiac reserve is limited even though heart failure may not be present. However, Rodman and Leaman[4] have concluded from a study of their series that patients with rheumatic valvular defects unaccompanied by signs of congestive heart failure are able to withstand surgical procedures well, as the stress and strain of an operation does not ordinarily exceed that of normal daily activity. Marvin[6] corroborates their findings with the often quoted statement that "a damaged heart, whatever its physical signs, is the equivalent of a normal one for anesthesia and operation if it is carrying on an adequate circulation under normal conditions of life, with the possible exception of the syphilitic heart." Marvin is also credited by Hermann[3] with the assertion that properly administered general anesthetics have an "absolutely innocuous cardiac effect."

Thus, the presence or absence of congestive heart failure rather than valvular defects is the important factor in operability. In general it might be fairly concluded that patients with nonsyphilitic valvular defects, who show no signs of congestive heart failure, are the equivalent of normal risks. Those with beginning congestive failure, presenting the symptoms of dyspnea on moderate exertion, undue fatigue and palpitation, but who have no demonstrable edema, dyspnea at rest or rales in the bases of the lungs, may be classed as fair risks. In this regard Willius[5] believes that the cardiac patient who requires an operation is in better condition to meet the ordeal if he is accustomed to being up and about than if he has had a prolonged period of inactivity.

Patients with signs of congestive heart failure are poor surgical risks and should not be subjected to surgery except when to refuse operation means almost certain death.

The breath holding test of Sebrasez, described by Woodbridge,[7] is of some value in the determination of cardiac reserve. If the patient is able to hold his breath for twenty-five seconds or longer, his cardiac and respiratory reserve may be considered good.

Hypertension and Hypotension

Another cardiovascular abnormality which has occasioned surgeons great unwarranted concern is arterial hypertension. In late years many authors have presented conclusive evidence that the height of the blood pressure has little influence on the death rate following operations.[8,9,10,11] The condition of the myocardium and kidney as a result of hypertension is of more importance than the hypertension itself.[11] Thus Trubek[9] advises that the presence of hypertension merely signifies the necessity of investigating for the underlying pathological condition. Changes in the retinal vessels, arteriosclerosis, history of cerebral vascular accidents, albuminuria and alterations in the urinary sediment are of great importance. But the absence of evidence of advanced renal or cardiac disease indicates that the hypertension may be disregarded in our prognostic conclusions, with the reservation that we keep in mind the possibility of cerebral hemorrhage. Proper preliminary care and intelligent choice of anesthetic to eliminate struggle will minimize this possibility.

McQuiston and Allen[11] reported a series of 350 patients with hypertension who were subjected to major operation with a mortality rate of 2.6 per cent. Only three of these deaths, or 0.85 per cent, were due to the hypertension.

The Moot–McKesson index of operability as determined by pulse pressure divided by diastolic pressure, the normal being approximately 0.50, has been discredited by Sykes[12]

who reported eight cases in which the indices gradually changed from "bad risk-inoperable" to "good risk-operable" as each patient approached death.

McQuiston[13] studied 250 patients with blood pressures below 100 mm. systolic, who were subjected to major operations, and concluded that they tolerated surgery as well as or better than unselected cases, but that the risk became greater in elderly patients, and was particularly bad in cases of Addison's disease. He also concluded that Moot's index does not apply to hypotensive patients.

Coronary Heart Disease

Of all the cardiac abnormalities coronary heart disease should give the surgeon most concern. A history of chest pain demands the most careful clinical and electrocardiographic study. Butler, Feeney and Levine,[8] in a study of 414 known cardiac patients who were subjected to operations, found that the highest mortality rate occurred among those with coronary disease. A recent coronary attack is a definite contraindication to surgery. Preoperative treatment with the usual vaso-dilating drugs is thought to improve the outlook in chronic or remote cases, but extensive elective surgery should not be performed upon these individuals.

It is well to remember that it is not uncommon for a patient to have a first and often fatal coronary attack while undergoing surgical treatment, and for this reason all patients over the age of 45 years should have careful preoperative clinical and electrocardiographic examinations. A careful inquiry may reveal a history of trepopnea or pain and dyspnea while lying in a certain position. This may manifest itself as angina pectoris. The longer the patient lies in this position, the worse the attack of pain becomes. Cardiac catastrophes during operations may be due to this condition, and thus it is vitally important that this position be avoided while the patient is under anesthesia.

With the exception of heart block and pulsus alternans, the cardiac arrhythmias do not appreciably increase surgical risk.

Patients with cardiac valvular lesions withstand surgery as well as normal individuals unless congestive heart failure is present. An exception to this is syphilitic heart disease.

Hypertension and hypotension without evidence of renal or cardiac damage do not appreciably increase surgical risk.

Coronary heart disease increases the danger of operation more than any other cardiac lesion.

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BLUE BOOK BEING PREPARED

Legal counsel and personnel of the State Medical Society of Wisconsin are now compiling up-to-date information on laws of Wisconsin relating to medical practice; services, facilities and officers of Wisconsin medical institutions, boards, commissions, and societies; the names and addresses of the entire membership of the State Medical Society, etc., for the Blue Book number of the Wisconsin Medical Journal, to be issued on December 10.

New Use For an Old Idea

By R. H. GRAY, M. D.
La Crosse

ON JULY 5, 1937, a boy, Maynard Evenson, 6 years of age, was brought into the La Crosse Hospital about 10 p.m. after having been struck by an automobile. He had sustained three large scalp wounds and fractures of both femurs at about the middle one-third.

The left femur was held in position by extensions and splints, but the right one continued to over-ride, so an open reduction was done and a mass of muscle was found between the fractured ends. On July 21, a Kohn clamp was applied by Dr. W. J. Jones, La Crosse, which held the fractured ends in alignment. This was removed on August 24, and each leg was left in the moulded plaster cast which had been applied previously.

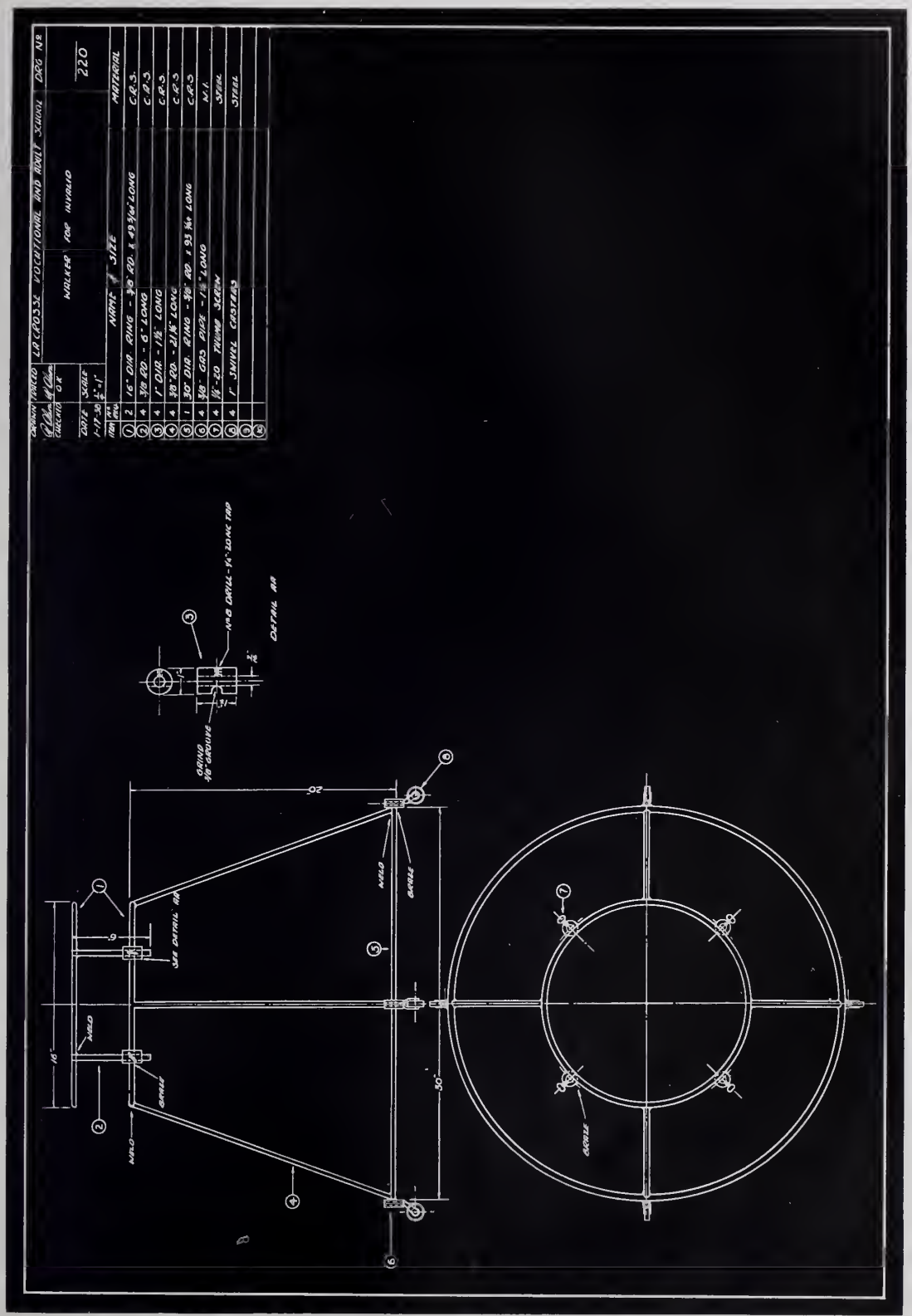
When the time came for the removal of the casts, the problem of re-teaching this boy to walk confronted us. Crutches were, of course, out of the picture because both femurs had been fractured.

One day while talking this problem over with the boy's mother, she said, "Maybe we could find one of those old fashioned baby strollers." None were available so we took our problem to Mr. John B. Coleman, superintendent of the La Crosse Vocational School. I explained to him what I wanted, and he and his co-workers planned the walker, as shown in the copy of the blue print on the opposite page and in the accompanying photographs. (The boy shown in the photographs is not the original patient.)

After the casts were removed the boy was placed in the walker and in three or four days he was rolling it from room to room resting on the seat as he choose. In a short time he discarded it entirely and soon was playing as usual. I saw him the first part of October, 1940; he walks without a limp, and both legs are equal in length.

The upper ring of the stroller is adjustable at different heights and a bicycle saddle is suspended by three pieces of rope to afford the child a seat.

Photographs by Raymond Bice, University of Wisconsin.



Reproduction of the original blue print of the walker used by Dr. Gray.

Maternal Care and Maternal Mortality*

With Special Reference to Progress in Wisconsin

By EDWIN F. DAILY, M. D.
Director, Maternal and Child Health Division, United States Children's Bureau Washington, D. C.

THE discussion of obstetric problems by members of the State Medical Society of Wisconsin began at their earliest meetings.

The first Wisconsin Territory Medical Society meeting was held in Madison the second Monday of January, 1842, and the Society first met in Milwaukee in January, 1850, just ninety years ago. One of the first recommendations made by the new medical society was for legislation to insure registration of births and deaths. Without such legislation requiring accurate registration, the birth and mortality rates which we refer to so frequently today would not be available. Your medical society held no meetings during the Civil War but reconvened in 1867. At that time the society recommended:

"That the great crime against the laws of God and man of provoking criminal abortions and destroying embryotic life is so common and is increasing so rapidly in these modern days that it is the duty of medical societies to bring the matter before the next legislature, asking that stringent laws be enacted for the punishment of so grave a crime."

It is interesting that abortions were considered such a major problem in Wisconsin over seventy years ago. We do not have records to show us how important a problem it was then as compared to today, but we do know that last year abortions accounted for one-fifth of all deaths in Wisconsin assigned to puerperal causes. The meeting held in 1868 was the first for which there are complete records of the proceedings. During this meeting one of the members discussed the treatment of hemorrhage following abortion, which is still a subject of frequent controversy and was the primary cause of 436 maternal deaths in the United States in 1938. In this same meeting in 1868, there was a case reported of a patient long left in labor by the attending midwife, a vesicovaginal fistula resulting. The physician reporting the case had repaired the large fistula with silver wire and obtained a perfect result since the patient a year later had no recurrence of any symptom. Another case presented at this meeting described a midwife's patient who after a long labor with shoulder presentation was delivered by a physician by version and extraction. Rupture of the uterus resulted but recovery was made without operation. The whole question of version and extraction in preference to forceps in cases of contracted pelves was discussed at this early meeting. Apparently many women in Wisconsin were delivered by midwives in those days. Last year more than 99 per cent of the deliveries in Wisconsin were attended by physicians.

The first committees of your medical society were appointed in 1868 and one of these was the committee on obstetrics—Doctors Treat, Rodgers, and McKennan, whose duties were to make an annual report on the subject of obstetrics and the diseases of women and children, giving a summary of the recent discoveries in this branch of medicine. Many of us, I am sure, have felt that maternal welfare committees were of rather recent origin.

One more brief quotation from the 1868 meeting:

"The subject of puerperal convulsions having been incidentally brought up, a very general and animated discussion upon the pathology and treatment followed. President Van Duzen left the chair and participated in his usual pointed and energetic style. He was full of the subject. Being an elderly gentlemen of large experience and close powers of observation, he was considered good authority upon the subject. His opinion was that it usually occurred in persons of a full or plethoric habit, and bleeding was the remedy. Such had been his prac-

* Presented at the 99th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1940.

tice and he had never lost a case. He had little faith in anesthetics without bleeding, and such appeared to be the general opinion."

We are still seeking the cause of eclampsia and are not in agreement on the best treatment, but more important we now know how to prevent the mild toxemias from becoming severe so that it is rare for a woman under good medical supervision to develop eclampsia. Only thirty-two women died from all types of toxemias of pregnancy in Wisconsin in 1938—approximately one toxemia death for every 1,700 births.

According to the records of these early meetings, obstetrics was the subject of greatest interest to the physicians practicing in Wisconsin over seventy years ago. This interest has been sustained over all these years and is in a large part responsible for the changes which have occurred.

"Since the Days of Those Pioneers in Wisconsin . . ."

Great advances have been made in the art and science of obstetrics since the days of those pioneers in Wisconsin. At that time prenatal care was unknown. Holmes and Semmelweis (1843 and 1846) had just made their great contributions to our knowledge of puerperal infection but their views were not generally accepted. Lister was then laying the foundation for antisepsis (1865). Fewer than 100 cesarean sections had been reported in the United States. Therapeutic agents such as pituitrin, progesterone and sulfanilamide were, of course, undreamed of. Let us compare a hospital maternity record of 1870 with the present. In 1870 at the Bellevue Hospital in New York, one out of every eighteen (5.5 per cent) women delivered died of puerperal infection. The staff of the Chicago Lying-In Hospital delivered 6,700 women in the last two years (July, 1938–July, 1940) with no deaths from puerperal infection. It would be interesting to compare maternal mortality rates from all causes seventy years ago with the rates today but this is impossible because of incomplete early records and different methods of classifying causes of death.

The decrease in maternal mortality in Wisconsin during the past ten years is probably of greater interest to us at this time. In the ten-year period between 1928 and 1938, the maternal mortality rate in Wisconsin was exactly cut in half—fifty-eight deaths per 10,000 live births to twenty-nine deaths per 10,000 live births. In 1928 one mother died for every 172 live births, while in 1938, one mother died for every 344 live births. During the same ten-year period the stillbirth rate in Wisconsin decreased by 21 per cent. Those are indeed statistics of which any state or country can be proud. A goodly share of the credit should go to the department of obstetrics at your State University where physicians are being taught sane, conservative obstetrics. Credit should also be given to the medical and nursing staff of the state and local health departments who have relentlessly preached the gospel of good maternal care. Yet I do not believe any of us can be complacent with the knowledge that in Wisconsin in 1938 there were 160 maternal deaths and over 2,500 (2,539) infants that were stillborn or died before they were one week old.

A careful study of each of those 160 maternal deaths would undoubtedly show, as it has in other areas, that at least half of them might have been avoided—if the patient had sought medical care earlier, if better facilities had been available in the hospital, if a consultant had been called before treating a serious complication, or if a blood transfusion could have been given a little earlier.

There were in Wisconsin, in 1938, 655 infant deaths in the first week of life from prematurity and 263 infant deaths in the first week of life from birth injury. Studies have shown that many of these deaths can be prevented by better obstetrical care throughout pregnancy, at time of delivery and during the postpartum period.

"Studies Have Been Made . . ."

Studies have been made in nearby Michigan of some of the factors which influence these mortality rates. A study of more than 10,000 pregnant women showed that 21 per cent had received little or no prenatal care. Some of these women did not know how important it was to seek prenatal care and others with limited resources who wished to have prenatal care may have found that

their community had not provided prenatal clinics.

The study of maternal mortality in Flint, Michigan, noted how much lower the mortality rate was when the patient was delivered by an experienced obstetrician than when the patient was delivered by a physician who practiced obstetrics only occasionally. The Hospital Obstetric Society in Ohio has shown how much higher the maternal mortality rate is in hospitals not approved for internship than it is in the approved hospitals. Studies of infant mortality made by the Chicago Health Department and its programs for the care of prematurely born infants have definitely proven that many of these infant deaths can be prevented by establishing a few well equipped and staffed treatment centers and by assuring proper care for every prematurely born infant in the city. One New England state health department recognizing the fact that the largest single cause of infant mortality today is prematurity has established treatment centers in forty-eight hospitals strategically located throughout the state. Immediate reporting of a premature birth is required, transportation to the nearest center is provided, and an intensive program of education in the care of premature infants is given to physicians, nurses and to the public.

Comprehensive studies of all factors relating to each maternal death have been carried out in many cities and several states by committees of physicians, and these studies have had a profound influence in improving obstetrical practice in the United States. In Chicago and New York City these studies have resulted in strict rules and regulations for the conduct of hospitals accepting maternity patients. In the course of one of these studies the committee soon noted that many of the deaths studied were due to hemorrhage; it was discovered that in the hospitals in which these deaths occurred there were no facilities for blood transfusion, and only a little effort was needed to correct the situation.

The new standard certificates of stillbirth and live birth adopted this year in Wisconsin and in many other states, when properly analyzed, will give us a far more complete picture of the conditions which are related to maternal morbidity and mortality. For the first time we will learn the incidence of various operative procedures and the incidence of all complications of pregnancy and labor so that correlation can be made between them and the data concerning survival or death of the mother and the infant.

Role of Government Agencies

The problem of providing good medical, nursing, and hospital care for the maternity patient is, of course, not limited to private practice. Approximately 20 per cent of all births in registered hospitals in the United States in 1939 occurred in government hospitals,—city, county, state and federal. A recent survey of births in 216 hospitals of all types in twenty-six cities showed that 29 per cent of these mothers were unable to pay for care. More than 200,000 deliveries each year, about 10 per cent of the total in the United States each year, are not attended by a physician.* Probably one-third to one-half of all women delivered each year in the United States are unable to pay for their medical care or for hospital care when needed. The government agencies, usually local or state welfare departments, responsible for providing care for the medically needy patients have a grave responsibility in establishing and maintaining the highest possible standards of service. Tax-supported hospitals should be models of efficiency and their staffs should include the best qualified physicians available. Physicians selected by the public agencies to provide medical care for needy patients should be selected on the basis of qualifications only and they should be paid for their services. The days are limited for the county "poor doctor" who was selected on a political basis or because he could not make a living otherwise. The administration of public medical services by welfare officials with little knowledge of medical need as compared to financial need has resulted in haphazard and poorly organized public medical service in many parts of the country. Many of us believe that all public (tax) funds appropriated for pub-

* Editor's Note—In Wisconsin less than 1 per cent are not attended by a physician.

lic health or medical care should be administered by the state and local health departments and that these agencies should be directed by thoroughly competent physicians selected on the basis of their training and experience and completely free of political control of any type.

A few state health agencies believe that their activities should be limited to educational measures. My own impression is that our efforts to educate the public have gone far beyond the facilities available in many communities to provide the care we have taught the patients to expect. It is futile to educate potential mothers to the need of good medical care throughout pregnancy and yet make no provision for them to obtain this care. What a waste of time and effort it has been in many areas to provide good prenatal care throughout pregnancy and then see all these efforts wasted because no care or a poor quality of care was provided at the time of delivery. I realize that the problems of providing good medical care are not great in Wisconsin because your per capita income is above the average for the United States as a whole and medical facilities of all types are fairly well distributed; but these problems are serious in many states and the official health agencies are making great efforts to provide medical, dental, nursing and hospital services for the maternity patients and infants who would otherwise not have this care.

"Under the Social Security Act . . . "

Under the Social Security Act, Congress has authorized an annual appropriation of $5,820,000 for extending and improving health services for mothers and children. The expenditures for these grants-in-aid are planned by and administered in each state by the state health department. (Wisconsin was allotted $98,219 of this amount for the fiscal year 1941.) I believe that as physicians you may be interested in some of the medical services being provided under these programs.

The state health departments have established more than 1,200 prenatal centers where physicians conduct clinics at least once a month and more than half of these have been established in the past two years. These prenatal clinics have of course only been established in areas where there were women who would otherwise not obtain this care. A total of 2,400 child health centers where physicians conduct conferences for infants and preschool children at least once a month have been established under the supervision of the state health departments. The Children's Bureau has recommended for many years that these clinics and conferences be conducted by the local practicing physicians best trained for this service and that these physicians be paid for their services. A total of 1,178 local practicing physicians are paid on an hourly basis for their services in conducting prenatal and postpartum clinics and 2,634 practicing physicians are paid for conducting the child health conferences. In fifteen states physicians are paid from these funds for delivering medically needy women. The expenditure of these funds for delivery care is limited to these few areas because the service is expensive and because few public health agencies in the past have administered funds for medical and hospital care. We are learning that this is feasible. To many of us it seems appropriate that the same agency providing prenatal and postpartum services should also be in a position to provide medical and hospital care at the time of delivery.

Studies of maternal deaths have shown that many could have been avoided if expert consultation had been available. Twenty-four state health departments attempting to meet this problem have made available clinical case consultation by specialists in obstetrics, usually on a fee basis. Since over 95 per cent of all specialists in obstetrics practice in large cities there are large rural areas and many smaller communities which do not have consultation service available except for those who can pay the fees for this service. The states are endeavoring to find the best method of making consultation service available except for those who can pay the fees for this service. The states are endeavoring to find the best method of making consultation service available to larger areas. In most instances lists of qualified consultants are prepared and these men are paid on a case basis by the health department. In areas where no specialists are available a

few full-time obstetricians have been employed to assist the local general practitioners.

Hospital care for maternity patients is purchased from maternal and child health funds in eleven states. Children's Bureau advisory committees have recommended high standards which must be met by these hospitals and the funds are approved for this purpose only when it can be shown that state or local funds are not available to pay for this service.

Postgraduate education in obstetrics for practicing physicians has been provided in all of the states. In 1939, 2,152 obstetric lectures and teaching clinics were held in 617 communities with more than 14,000 physicians attending. Short clinical courses of graduate obstetric education are now provided in teaching hospitals by state health departments in cooperation with fourteen university medical schools.

More than 6,000 public health nurses are now rendering services under the maternal and child health program in 2,000 of the 3,076 counties in the United States. In 102 counties the health departments have made available at all times trained nursing assistants to the physicians for home deliveries. These and many other types of health services developed to meet the needs of the individual community or state are being provided from Puerto Rico to Alaska and from Hawaii to the northern-most tip of Maine.

Results of the widespread efforts to improve the health of maternity patients as shown by mortality rates are extremely gratifying. During the first four years—1936 to 1939—that the maternal and child health services were provided on a nationwide basis under the Social Security program, the maternal mortality rate decreased more than 30 per cent. If the maternal mortality rate for 1935 had remained unchanged in 1936, 1937, 1938, and 1939, there would have been 10,180 more maternal deaths during these years than actually occurred. In other words, there are more than 10,000 mothers living today in the United States who would have died in the past four years if the maternal death rate of 1935 had prevailed. Better education, better medical, nursing, and hospital care, and the wholehearted cooperation of the public, physicians, nurses, the public health agencies, and others have made this saving of life possible.

Advances as great or greater can be made in the next four years.

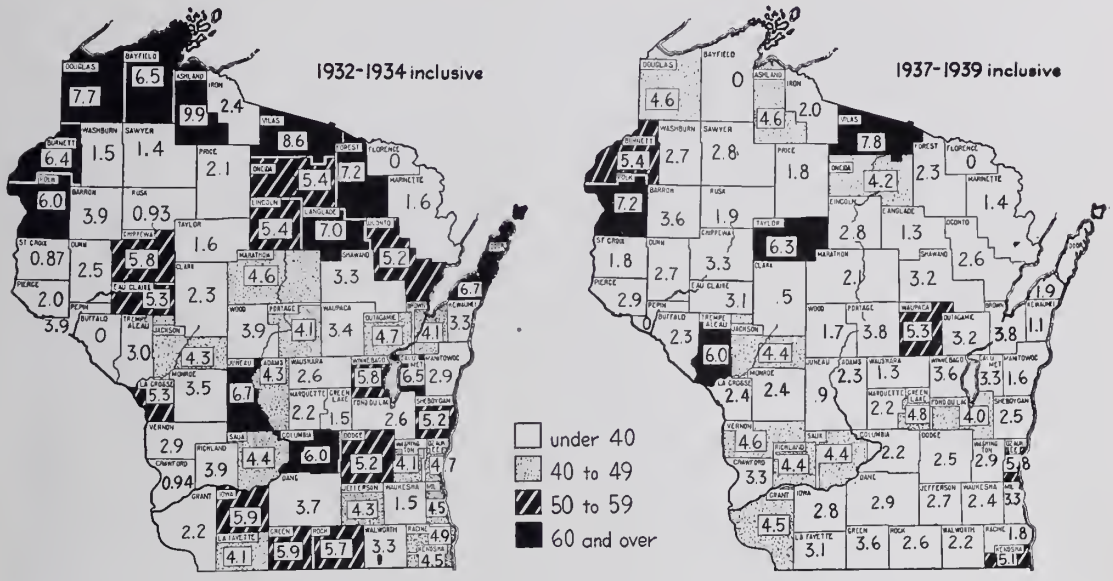
Wisconsin Marches On

By AMY LOUISE HUNTER, M. D.
Bureau of Maternal and Child Health, State Board of Health
Madison

PROGRESS always brings a sense of satisfaction. Every doctor in Wisconsin can look with pride at the advances made in the last few years in the reduction of maternal and infant deaths within the state. Total annual maternal deaths dropped from 225 in 1932, to 153 in 1939. Total infant deaths were reduced from 2,670 to 2,172. These lower total deaths have occurred even though there has been an increase in births. Actually, our change in maternal death rate has been from 4.2 to 2.8 per 1,000 live births—a drop of 33.3 per cent—while the infant death rate dropped from 50.0 to 40.1, or 20.0 per cent for the state as a whole from 1932 to 1939.

Since many doctors have a very real interest in the problems of maternal and infant deaths, we are presenting for comparison the rates by counties for two three-year periods. It will be noted that the averages for individual counties are compared on the basis of three-year periods rather than on single years. This is done to eliminate the probable error involved when statistics of this type are based on too low figures. Even on this basis, a few of the counties in the state have less than 750 births in the three-year period, so that the statistics shown for Adams, Burnett, Florence, Green Lake, Iron, Marquette, Pepin, and Sawyer counties are somewhat less significant than those

WISCONSIN MATERNAL MORTALITY RATES
PER 1,000 LIVE BIRTHS



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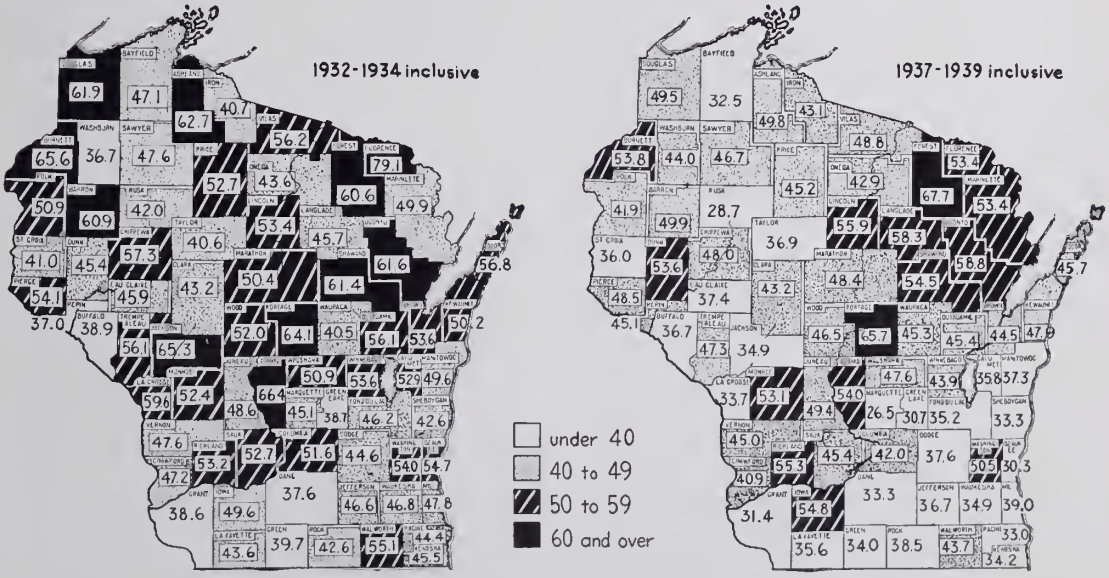
WISCONSIN INFANT MORTALITY RATES
PER 1,000 LIVE BIRTHS



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for counties with more births, since a single birth or death tends to increase the rates markedly. Check your county and see where it stands.

The program for further reducing maternal and infant deaths is that of every practicing physician. There is something that each can do whether or not he specializes in obstetrics or pediatrics. There is, for instance, the important need of re-educating the public to understand that pain relief is not quite as simple as certain articles which have appeared in recent years in the lay press would have us believe. Too often now individuals make their own decisions as to the type of treatment they should receive, basing it on popular magazine articles. We need to combat the release of such misinformation which now appears. The physician should also do everything in his power to see that any hospital with which he is associated meets standards; that the nurses in the hospitals have adequate supervision and that techniques are rigidly maintained. Nurses with upper respiratory infections should not be allowed to continue their duties. More careful and complete filling out of all birth and death certificates would aid in analyzing problems. Consideration at staff meetings of every maternal or infant death occurring in the hospital would bring to light much information that might lead to the further reduction of deaths. We need to know more about the increasing number of maternal deaths associated with embolism and with hemorrhage. Requirement of consultation prior to all operative procedures on obstetrical cases would merit consideration. Doctors can encourage routine supervision of the pregnant woman from the time of conception, and routine health supervision of the baby after birth, beginning with a detailed appraisal of the newborn. Parents need to be repeatedly encouraged to have preventive procedures carried out routinely in the doctor's office.

Local public health nurses can offer real assistance if prenatal cases are routinely referred to them. These nurses can be especially helpful to the physicians who are doing home deliveries by teaching preparation for such deliveries in advance, and in the postnatal demonstration of caring for the newborn baby. Careful nursing supervision is especially important for the premature baby, and the public health nurse can offer real assistance to the physician who delivers a premature baby in the home. Also, through the local nurse, an incubator for home use where necessary can usually be obtained. This care of premature babies is important for they still account for the largest number of infant deaths—36.6 per cent of the 2,172 infant deaths occurring in Wisconsin in 1939. It is interesting to note that this is approximately 8 per cent higher than the figure for the United States for 1938. Do we have a higher proportion of premature babies in Wisconsin? Can more of these babies be saved? We need the assistance of every physician in answering these questions.

Wisconsin is fortunate in being spared some of the problems of other states. More than 99 per cent of the deliveries are by physicians. Standards of living in Wisconsin are definitely above many states. We do not have racial problems. Sixty-three of the seventy-one counties have locally organized and directed public health programs with local physicians participating in program planning. With the great corps of well trained physicians and the educational and institutional facilities available, Wisconsin should lead the nation in low infant and maternal deaths. Will you help to place Wisconsin in this position by the end of the next three-year period? The State Department of Health can aid every physician through analysis of data available, and through educational programs, but the real responsibility for life conservation rests largely in the hands of the practicing physician.

POSTGRADUATE COURSES ANNOUNCED

The Department of Obstetrics and Gynecology of the University of Chicago and the Chicago Lying-in Hospital through the cooperation of the Children's Bureau, U. S. Department of Labor and the Illinois State Department of Public Health offers five postgraduate courses of four weeks each between January 6 and June 21. The beginning dates of each are: January 6, February 10, March 17, April 21, and May 26. All the members of the department and all services and units of the institution participate in the instruction. Only a limited number of postgraduate students are accepted for each period. A deposit of $25.00 is required, of which $10.00 is returned on completion of the course. All communications should be addressed to: Postgraduate Course, 5848 Drexel Avenue, Chicago, Illinois.

Comments on Treatment

EDITORS
A. J. Quick M. D., Marquette University, Milwaukee
and
M. H. Seevers, M. D., University of Wisconsin, Madison

A Classification of Drug Toxicity

In the enthusiastic reception of new drugs, the fact of toxicity is often overlooked or greatly underestimated. This indifference is in part explained by the lack of understanding of drug action. Broadly, drug toxicity can be divided into 3 classes.

1. Direct immediate action.
2. Direct but delayed action.
3. Indirect or idiosyncratic action.

The first class is the easiest to understand and causes the least trouble, since the lethal dose can be determined readily by experimental methods. Strychnine serves as a perfect example of the first class. The action of this alkaloid is specifically on the spinal cord resulting in typical tonic convulsions and usually causing asphyxial death. The minimum lethal dose can be accurately determined. Most of the common drugs such as morphine, atropine, chloral, ether and epinephrine, similarly have a direct and immediate action which every practitioner knows thoroughly.

The second class, unfortunately, is not so simple. The direct delayed action also recognized as cumulative action is often insidious and hard to predict or control. Many of the industrial toxins come under this category. Thus, the slow accumulation of lead, causes no direct immediate reaction. The toxic manifestions such as anemia, colic, peripheral paralysis and arteriosclerosis often appear months or years after constant exposure. Likewise benzene or benzol does not exhibit any pronounced direct toxic action, but its effect on bone marrow with the resulting anemia, though delayed, is nevertheless direct since it always follows exposure to this poison. Perhaps the most classical example of delayed poisoning is found in the tragic episode of the New Jersey radium workers. Every girl who, in painting luminous dials on watches, took radium into her system, was doomed even though in some of the victims death occurred only after five years. Recently the most spectacular instances of delayed poisoning have been the peripheral paralysis following the drinking of artificial ginger, (which is triorthocresyl phosphate), and the fatal anuria resulting from the ingestion of diethylene glycol, as occurred in the intensively studied cases that developed following the use of Elixir of Sulfanilamide-Massengill. The serious toxic action of both triorthocresyl phosphate and diethylene glycol are all the more impressive because no serious immediate ill effects are usually observed. But the toxic action though delayed is definite and specific. Triorthocresyl phosphate acts as a neurotoxin and when ingested produces the characteristic bilateral foot drop and other signs of peripheral neuritis which is recognized by the popular name of "jake paralysis." Diethylene glycol causes extensive damage of the renal epithelium both in man and in experimental animals. Fortunately, the type of toxicity which is delayed but direct can almost always be readily determined by careful animal experimentation, and it seems certain that under the new federal Food and Drug Act, the haphazard marketing of new drugs is swiftly coming to an end.

The third type of toxic action often referred to as idiosyncrasy is the most difficult with which to cope. A. J. Q.

In the Jan. issue of *The Journal* Dr. Quick will discuss the type of drug toxicity last referred to above, namely, indirect or idiosyncratic action.

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« « « EDITORIALS » » »

The Common Cold

THE problem of the common cold seems to stand almost exactly where it has always been. It is still unsolved. The common cold runs rampant each season. It is no small problem. The average citizen has from two to four "colds" a year depending largely upon the age group to which he belongs and upon the amount of exposure.

The nature of the common cold is not definitely known, though its extreme contagiousness is generally admitted. It is probably due to a virus which is followed (not invariably) by secondary invading organisms—the streptococcus, staphylococcus, pneumococcus, or a number of others, generally mixed. That there is any considerable immunity to the common cold has not been shown. That there may be substantial immunity to the secondary invaders is accepted by all.

Great claims have been made that a high vitamin intake will raise resistance against infection. Thousands of dollars are spent every month for this purpose. Vitamins A, D, and C are chiefly stressed. On what grounds does this belief rest when it concerns resistance to the common cold? It rests on no scientific ground. On general grounds there is much evidence to the contrary. People who go South in winter, bask in the sun, eat freely of a high vitamin diet with quantities of fresh fruit, succumb to colds almost invariably as soon as they reach the North, if they do not stay in the South beyond the "cold" season. By the same token thousands of the children who spend their summer vacations in the open air and at camps have colds as soon as school starts in September, before bad weather begins. In other words, it would seem that what resistance one has is lost during the summer or during a sojourn in the South. It was true that during the "flu" epidemic in 1918 and 1919, the country boys of finer physique and healthier habits were more susceptible than the city bred boy who lacked sunshine, vitamins and whose hygiene generally was poorer.

Another moot point in regard to resistance to colds is in the value of vaccines. Reports

are conflicting, but the consensus of opinion seems to be that they are of no value. How could they be against a virus which is unknown? That they do not help to prevent the secondary invaders may be due to the fact that the preventive treatment is never begun until the cold season is well under way; and we all know that in order to establish immunity one must begin well in advance of the time of contagion. The administration of cold vaccines should be started in June or July. The use of vaccines to prevent colds in college students, beginning in September or October for the current season, is like giving coseasonal treatment for hay fever. It may help, but it may not. At any rate it is not the accepted way of giving treatment.

I should like to see cold vaccines used with the avowed purpose of preventing the effects caused by secondary invaders, like the streptococcus, staphylococcus and pneumococcus, and have them started well in advance of the fall season. The results might be very different from the usual coseasonal use that has been reported in the literature.

Circumstantial evidence seems to show that one cannot be away from these common infecting organisms more than six to eight weeks without losing some or all immunity. The city bred boy who swallows his daily dose of bacteria is better protected than the country boy. Both are better off than the Eskimo or the Figi islander.

"Mr. District Attorney . . ."

ON PAGE 969 of this issue of The Journal, we are privileged to present a special article by Dr. Theodore G. Klumpp, chief of the drug division, United States Food and Drug Administration. Dr. Klumpp's article, written at our request, discusses the significance of the new federal food, drug and cosmetic act and is worthy of careful reading by every member of our Society.

We take this space, however, to call particular attention to that section of the article entitled "Limitations of Act," on page 972. The author here discusses out of his broad experience the exploitation of a public seeking relief from illness from those who prey upon the credulous sick. Dr. Klumpp points out that the dangers to the public health are not theoretical, but real; and that just as it is the duty of the physician to give of his best to his individual patient, so do illegal activities of cultists present even a broader call to public service.

In Wisconsin the State Board of Health has an investigator assigned to such effort. But a single investigator, valuable as has been his public accomplishment, is without the time or funds to attempt to handle all law violations in seventy-one counties. Nor should he be required to do so. Under the laws of the state each county has a district attorney. He is the law enforcement official in that county.

If, as physicians, we are to meet the public service task laid down to us in such clear terms by the chief of the drug division of the United States Food and Drug Administration, we may well begin at home by seeing that each district attorney of the state has the opportunity to read this enlightening article and give all possible and proper cooperation to the end that in his discharge of his official duties he reaches those who would rob our citizens of their most priceless possession,—their health and the opportunity to maintain it.

Maternal and Child Health

ON PAGES 940–946 of this issue appear two articles that set forth the tremendous gains in Wisconsin in the field of maternal and child health. Wisconsin has a record in this field that is equalled by no large country in the world. As we view the problem ahead of us, let it be with the encouragement that is always to be found in the team that is winning.

In viewing the charts indicating the county by county record it should further be kept in mind that the numbers involved in certain areas are not as sound a basis for percentage estimation as in other counties of the state.

Withal, the pride of accomplishment will, we are certain, lead us on to new health records in the future.

. . . . THE PRESIDENT'S PAGE . . . .

Daylight Saving

IT DOES not seem possible that one month has elapsed since the annual meeting. Since that time my incoming mail has been tremendous. It comes from people in all walks of life and must remain largely unanswered. I sent up a trial balloon one day on daylight saving. The thought was entirely directed toward daylight saving from a health point of view. The response from the press and the public was most unusual. Hardly a day passes that some business man, preacher or cab driver does not offer his services in behalf of this project. To date there is surprisingly little unfavorable comment.

At present, local talent is working on round table discussions of fifteen minutes' duration for broadcasting purposes. A dozen such programs are in prospect for Sunday afternoon rendition. The Milwaukee County Medical Society has endorsed daylight saving. Those who will participate in the discussions include business men, laboring men, farmers and physicians. The subject matter will be entirely confined to the health issue.

It is my hope that you as physicians and auxiliary members will enter into this program with whole-hearted support. There is nothing that will improve our relations with the public more than the proper execution of this project. With your help a bill will be presented to the legislature in proper form and should pass. Your constructive criticism on this matter and any other during the course of the year will be very much appreciated.

Ralph P. Sproule

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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Why an Enlarged Circulation of the Bulletin?*

BY MRS. V. E. HOLCOMBE

National Auxiliary President, Charleston, West Virginia

TO THE Woman's Auxiliary to the State Medical Society of Wisconsin: I bring you greetings and express my appreciation for the opportunity of meeting with you on this enjoyable occasion.

The nineteenth year of the National Auxiliary is well under way. Ere this, I am sure you have realized that our project for the year 1940–1941 is to increase the circulation of the *Bulletin,* our official organ. In selecting this project for the year, we have done so with the full realization that we have selected a hard one.

Do you want to know what the Auxiliary stands for? Do you want to know more about the program of the Auxiliary and the working of each of the several committees, —exhibits, Hygeia, legislation, organization, press and publicity, health education, and public relations; why so many fine, intelligent women are giving much of their valuable time to this organization; why the doctors themselves encourage the growth and expansion of our activities as an organization?

Read the *Bulletin,* the Auxiliary digest. Become informed on the whole program of the Woman's Auxiliary to the American Medical Association and its component auxiliaries.

Mrs. V. E. Holcombe, Charleston, West Virginia; president, Woman's Auxiliary, American Medical Association.

* Condensation of the address by Mrs. V. E. Holcombe, president of the Woman's Auxiliary to the American Medical Association, to the Woman's Auxiliary to the State Medical Society of Wisconsin at its twelfth annual session, Milwaukee, September 17–19, 1940.

"LEFT-RIGHT . . . LEFT-RIGHT
Now's the time to make a fight!
Swell your chest and draw your chin:
Publicize our BULLETIN!
Learn the things you'd like to know—
Why we are—And how we grow
Who is who—And what she says—
Learn the problems of our days.
Read our plans on how to meet them
Lend a hand and help defeat them.
March together! Side by side!
Send our message far and wide!
Face this project with a grin—
ORDER NOW . . . THE BULLETIN."
M. F. C.

Little did I realize when I became president of the Auxiliary that I should soon be forced to become a mere "sales agent" for our periodical. Yet here I stand before you, ready to present my little sales talk regarding the publication of the Woman's Auxiliary to the American Medical Association. And, in passing, I would have you to realize that I am not working my way through college, finishing-school or an N. E. A. correspondence course by stimulating such circulation. I am working solely and simply in behalf of the Woman's Auxiliary in its efforts to make our organization a constructive force in furthering the programs and ideals of the American Medical Association.

In this connection there are two questions which I have often been asked. First, "Why do you place so much stress upon the importance of the *Bulletin*?" Secondly, "Is it really so all-important that this publication have a large circulation?" With your kind indulgence, I shall for the next few minutes attempt to point out the purposes behind this drive for a more extensive circulation of the *Bulletin.*

Many of these purposes are quite obvious and self-evident. For instance, it is probably unnecessary for me to go into the virtues of the *Bulletin* as a medium for the spreading of information regarding the work of the Auxiliary. Neither would it be required of me to describe in meticulous detail the value of the *Bulletin* in fostering intelligent interpretations of the plans of our various county and state organizations, and as a stimulator of interest in our individual and collective activities.

Nevertheless, it is these and other factors which I feel must be emphasized, and it is only by constant, almost monotonous, emphasis that we can hope to lift the *Bulletin* from the depths of neglect into which it has fallen. For those of you who possibly may not be entirely up-to-date in this respect, I might just mention that the *Bulletin* is merely the new name which has been given to the publication that was formerly called the "News Letter."

In the light of the fact that the *Bulletin* should hold such a high place in our organization, one is appalled at the great gap between conditions as they are and as they should be. A very small percentage of our membership make the *Bulletin* a vital factor in their thinking and working, and there is need of repeated emphasis to induce more of us to give serious attention to this vital publication. The *Bulletin* is published for the express purpose of furthering our fellowship and propagating the principles and ideals of our organization.

A competent editorial leadership directs and guides the policy of the *Bulletin.* Authoritative writers and otherwise discerning observers present, from time to time, a sweeping panorama of events of interest and importance. Our members should read this periodical, because it conveys to them information of what other members are doing. They may feel that they have problems and hardships such as none others ever have, but in the *Bulletin* they may read that others have faced even more difficult situations and have found a way to solve them. Thus a tie of interest and understanding is formed through the channels of the *Bulletin.*

If we want to attain the goals set before us, our members need to be brought in touch with them through mutual information. The *Bulletin* is our best medium of disseminating information for it gives our members the main facts about the activities in which our organization is engaged and presents the essential features of what is transpiring in our organization.

An organization without appropriate and special literature is like a garden without plants. The possibilities for growth are there, but there can be no good fruitage

without the planting of seeds and the cultivation of the plants. The power of the *Bulletin* in your organization is dependent upon whether or not it is given a place there. No instrument of righteousness, however excellent, can affect for good those whom it has no opportunity to touch. There is no magic power in food to nourish those who fail to partake of it. Likewise there is no efficacy in a *Bulletin* that is never read.

If we can but persuade our membership to give more consideration to the *Bulletin* we will make a sound investment, certain to be productive of future gains. Each member of our Auxiliary should realize her responsibility to our publication. Why? First, because it has an educational force, which is of particular value to each member and to the profession of medicine as a whole.

Everyone recognizes this truth—that progress in any profession is dependent on facts, observations and conclusions communicated by one individual to another and recorded for future generations, each generation building on the foundation work of former generations. Advancement is thus in direct relationship to the improvement of facilities for the exchange and interchange of facts, information, knowledge and truth, and the proper use of those facilities.

It is with this truth in mind that our *Bulletin* is published. Through it new ideas and new knowledge are transmitted to the various members of our Auxiliary. Many valuable ideas would die with the originator were it not for the aid given by the *Bulletin* in providing them with an audience.

With your help our publication can be made one of the most important reservoirs of thought. With these ideals in mind, I ask each member of the Auxiliary to take a renewed interest in the *Bulletin*. Today there is hardly an existing organization of any size or significance that does not have a periodical.

In this connection, I might add that the American Medical Association not only publishes the Journal of the American Medical Association and other scientific periodicals but also the health magazine Hygeia, in order to keep its members and the public in general informed regarding the various developments of medicine. The state societies also have their own local journals, all of which are of the utmost importance to the medical profession.

Our *Bulletin* could be equally important and valuable, but this aim cannot be realized unless it is well subscribed to and supported. The immediate goal of our Auxiliary is to increase the circulation of this publication to include at least one-fourth of our membership, and I feel confident that the members of the Auxiliary will lend their support that this may be reached. With proper support, the Woman's Auxiliary to the American Medical Association will have a periodical of which it may well be proud.

Hygeia

By MRS. GERALD H. FRIEDMAN
Milwaukee

Arise, ye wives of A. M. A.
Please cause me no dismay.
Listen to an idea
To encourage our daughter Hygeia.
To reach your goal
You need only add your 1940 roll.
Be it by benefit or assessment
It really is a good investment.
For health is wealth
And wealth is health.
This is the message for you to carry
So that we may all be merry.
Do not tarry
Lest you become wary.
Vim, vigor, and vitality
Will bring you reality
In subscriptions and honorable mention
Which surely is your intention.
And so, my fellow-workers, I say
All Hail!
Hygeia will prevail!

AN EDITORIAL in the *Journal of the American Medical Association* in December, 1922, explained the "need for a periodical through which the public might be enlightened in medical science." In June,

1922, in St. Louis, the Board of Trustees of the American Medical Association was vested with the authority to take steps for the publication of a scientific but non-medical journal. The first issue of Hygeia appeared in April, 1923, this particular name being selected because in Greek mythology Hygeia was the goddess of health.

A magazine having a circulation of 125,000 must merit this popularity. Among its enthusiastic readers are educators, health and welfare workers, nurses, dentists, doctors, housewives, parents, and beauticians. *The Reader's Digest*, one of the best and most widely read periodicals, frequently contains condensed Hygeia articles. The March and April numbers of the 1939 *Reader's Digest* contained these excerpts: "Spyglass on Man's Interior" and "These Short-Wave 'Health' Machines."

Forthcoming articles in Hygeia will be of great interest to the general public: *"Toast"* by James A. Tobey. What is the best bread for toasting from a dietary and nutritional standpoint? *"Your Feet and Your Children's"* by Ellen Kelly. What happens when shoes or stockings are too small? In buying shoes what features should be considered? *"Home is Where the Danger Lies."* How do you make your home safe? The excellent advice of this article will teach you how to avoid accidents in your home.

To familiarize you with the purposes of Hygeia, permit me to quote its purposes as outlined by its governing board:

1. To supply its many subscribers in their wide fields of endeavor with reliable, informative material about health and hygiene.
2. To encourage healthful living and community hygiene.
3. To discourage self-medication and adherence to fads, cults, and quackery.
4. And to contribute toward reduction of mortality and morbidity to its lowest level.

Keeping these aims in mind, your state Hygeia chairman has worked out and distributed to the twenty-seven county auxiliaries in Wisconsin this program for 1940–1941:

Each year the importance of health education has increased. Aware of this factor, the House of Delegates to the American Medical Association has asked all auxiliaries to make health education through the distribution of Hygeia, one of its major projects. Keeping this in mind, these points were stressed:

1. Object—to promote health education among the laity by the distribution of Hygeia to these special groups: hairdressers, barbers, druggists, educators, health and welfare workers.
2. Minimum quota—one subscription per auxiliary member to be raised either by assessment or benefit, depending upon the wishes of the individual auxiliaries. Renewals of yearly subscriptions will count as new ones.
3. Final date to report results to state Hygeia chairman, December 16, 1940.
4. Cash prizes will be awarded to county and state auxiliaries for the greatest number of proportionate subscriptions.

The State Medical Society is bending every effort to assist the Woman's Auxiliary in making this program successful. With the combined efforts of these organizations, there is every assurance that this will be a banner year.

"The health of a nation is its highest and best asset." It is only by health education that a nation's health standard can be raised. What better method is there to educate the laity than by the distribution of the most authentic health magazine with its well-written, scientific, non-technical articles on food, exercise, rest, sleep, child welfare, sanitation, health habits, and prevention of disease?

Last year Wisconsin received fourth place in the National Hygeia Contest. If every Auxiliary member in Wisconsin takes the responsibility of accrediting herself with one or more subscriptions, her cooperation as a health educator will put our state in first place.

The regional chairmen who are assisting your state chairmen are:

Mrs. H. E. Kasten, Beloit
Mrs. J. V. May, Marinette
Mrs. A. N. Nelson, Clear Lake
Mrs. T. A. Teitgen, Manitowoc

Douglas

The Woman's Auxiliary to the Douglas County Medical Society met Monday, October 7, 1940 at the Androy Hotel in Superior. A one o'clock luncheon was served to sixteen members. Miss Aimee

Zillmer of the State Health Department was the speaker, her subject being "Social Hygiene."

The Auxiliary made a special project of presenting Miss Zillmer to twelve different civic organizations, including all of the P. T. A. groups in the city of Superior, all of the Junior and Senior High Schools in the city and the county, the Teacher's College, and some classes in the college. Miss Zillmer was kept busy for two weeks on this project sponsored by the Auxiliary.

Milwaukee

The first autumn meeting of the Woman's Auxiliary to the Medical Society of Milwaukee County was a chrysanthemum tea and musicale, October 11, 1940, at the Hotel Astor. At the tea table, two past-presidents, Mrs. W. M. Jermain and Mrs. R. G. Washburn, presided. Yellow candles and yellow and rust chrysanthemums served as a centerpiece. Sixty-five members and guests attended.

Mrs. C. D. Partridge, president, introduced Mrs. J. R. Dundon, co-chairman of the music committee who, in turn, introduced three well-known Milwaukee musicians. Violin selections were played by Miss Teresa Rybold, accompanied by Mrs. H. P. Ringler. The latter also accompanied the contralto soloist, Grace Dittmer Kerler. This delightful program concluded with piano selections by Mrs. Ringler.

Mrs. W. C. Liefert, chairman of the Auxiliary's committee on Red Cross work, told how this work had been carried on during the summer and asked for continued cooperation.

Mrs. G. H. Friedman, state Hygeia chairman, presented the program for 1940–1941 and was assured cooperation by members of the Milwaukee County Auxiliary.

The next meeting will be held Friday, November 8.

Sauk

(Organized in 1940)

A luncheon meeting of the Woman's Auxiliary to the Sauk County Medical Society was held on Friday, September 13, at the Lake Delton summer home of Dr. and Mrs. J. F. Moon. There were eleven members present.

During the business meeting, the constitution of this newly organized group was presented and accepted. Chairmen of three committees—Hygeia, philanthropic, and press and publicity—gave reports received from state chairmen of their respective committees. Members decided they would like to do Red Cross work as a group project, and it was voted to make inquiries about this possibility before the next meeting.

Sheboygan

A one o'clock luncheon at the home of Mrs. C. M. Yoran at Rocky Knoll Sanatorium, Plymouth, followed by a business session and bridge, opened a new season of activity Wednesday, October 2, 1940, for the Woman's Auxiliary to the Sheboygan County Medical Society. Co-hostesses with Mrs. Yoran were Mrs. A. J. Brickbauer of Plymouth, new president of the organization, Mrs. J. A. Russell of Random Lake, and Mrs. I. M. Bemis of Batavia.

Guests at the delightful opening meeting included Mrs. Charles Shager of Sharon, state president of the American Legion auxiliary, who was visiting Mrs. Brickbauer; Mrs. Robert Scobie of Chippewa Falls, house guest of Mrs. P. B. Mason of Sheboygan, and Mrs. Victor Neu, wife of Dr. Neu, a new member of the Sheboygan Clinic staff.

During the business session announcement was made of committees for the following year as follows:

Program and social—Mrs. L. C. Dietsch, Plymouth; Mrs. J. J. Boersma and Mrs. F. A. Nause, Sheboygan, and Mrs. J. A. Russell, Random Lake

Hygeia—Mrs. H. J. Hansen, Sheboygan Falls; Mrs. A. C. Radloff, Plymouth; Mrs. I. M. Bemis, Batavia, and Mrs. C. J. Weber, Sheboygan

Membership—Mrs. J. W. McRoberts, Sheboygan

Public relations—Mrs. W. G. Meier, Mrs. P. B. Mason, and Mrs. G. J. Juckem, Sheboygan

Telephone—Mrs. W. W. Van Zanten and Mrs. W. G. Huibregtse, Sheboygan

Publicity—Mrs. Ludwig Gruenewald, Sheboygan

Bulletin—Mrs. C. M. Yoran, Plymouth

Historian—Mrs. G. J. Hildebrand, Sheboygan

Bridge followed the business meeting, those receiving prizes being Mrs. W. A. Ford and Mrs. F. A. Nause of Sheboygan.

Washington-Ozaukee

The Woman's Auxiliary to the Washington–Ozaukee County Medical Society began a new year with its meeting at Hartford on October 10. Twenty members were present. A luncheon at the Hilt Cafe was followed by a business meeting at the home of Mrs. F. W. Lehmann.

The retiring president, Mrs. A. H. Barr of Port Washington, was presented with a corsage by the Auxiliary members in appreciation of her year's work, and was congratulated on her appointment as state press and publicity chairman for 1940–1941. Mrs. Barr in turn thanked the members and committees, and presented a corsage to her secretary-treasurer, Mrs. P. B. Blanchard of Cedarburg, whose duties required an unusual amount of time due to the widely scattered residences of the members.

Mrs. A. H. Heidner of West Bend, the new president, announced her committees for the year as follows:

Membership—Mrs. C. H. Kalb, Grafton, chairman; Mrs. M. E. Monroe, Hartford; Mrs. R. S. Fisher, Allenton

Scrapbook, archives, and history—Mrs. K. T. Bauer, West Bend, chairman; Mrs. W. J. Wehle, West Bend; Mrs. R. S. Fisher, Allenton

Nominating—Mrs. M. E. Monroe, Hartford, chairman; Mrs. A. H. Barr, Port Washington; Mrs. H. E. Froede, Jackson

Press and publicity—Mrs. A. H. Barr, Port Washington, chairman; Mrs. O. J. Hurth, Cedarburg; Mrs. C. P. Kauth, Slinger; Mrs. H. M. Lynch, West Bend

Public relations—Mrs. P. B. Blanchard, Cedarburg, chairman; Mrs. K. T. Bauer, West Bend; Mrs. A. H. C. Carthaus, Thiensville

Program—Mrs. H. M. Lynch, West Bend, chairman; Mrs. M. E. Monroe, Hartford; Mrs. R. K. Pomeroy, Port Washington

Hygeia—Mrs. F. W. Lehmann, Hartford, chairman; Mrs. T. J. Kern, Richfield; Mrs. W. H. Drissen, Port Washington; Mrs. J. E. Reichert, West Bend; Mrs. O. W. Hurth, Cedarburg

Philanthropic—Mrs. O. J. Hurth, Cedarburg, chairman; Mrs. H. M. Lynch, West Bend; Mrs. David Fisher, Fond du Lac

Other new officers are: Mrs. M. E. Monroe, Hartford, president-elect; Mrs. H. E. Froede, Jackson, secretary-treasurer. Mrs. R. K. Pomeroy of Port Washington was welcomed as a new member.

Reports of the state convention were given by Mesdames Heidner, Barr, Hurth, and Monroe. It was voted to limit the price of luncheons to 75 cents including tips and occasionally to dispense with luncheon and have a dessert course served in a home by a group of hostesses at the beginning of the meeting.

Twelve members volunteered to do sewing at home for the Red Cross. All articles will be cut out and ready when received. Two members volunteered to knit. The Red Cross work is in charge of the Philanthropic Committee and will be obtained alternately from the Washington and Ozaukee County Red Cross Chapters.

Winnebago

Mrs. W. N. Linn, Oshkosh, was named president of the Woman's Auxiliary to the Winnebago County Medical Society at a luncheon meeting on September 23 at Stein's. Mrs. G. C. Owen, Oshkosh, is president-elect, and Mrs. E. B. Williams, Oshkosh, is secretary-treasurer. Retiring officers are Mrs. R. H. Bitter and Mrs. H. A. Romberg, both of Oshkosh.

There were twenty-one members at the meeting, at which Mrs. R. H. Bitter presided. She called for reports of the various committees, in which it was revealed work of the year just past was successful. Mrs. F. G. Connell, Oshkosh, and Mrs. T. D. Smith, Neenah, gave interesting reports of the state convention they attended in Milwaukee in September as delegate and alternate delegate respectively.

THE BULLETIN

Have you read the October issue of the *Bulletin* of the Woman's Auxiliary to the American Medical Association? It contains the addresses of Mrs. V. E. Holcombe, our national president, and of Dr. Nathan B. Van Etten, president of the American Medical Association, which were given at the national convention in New York. In these addresses and in Mrs. Holcombe's article "Look Forward" you will find many definite suggestions for the work of your Auxiliary for the coming year.

There are also articles by national chairmen as follows: Program, Mrs. Walter F. Donaldson; public relations, Mrs. Henry Raile; Hygeia, Mrs. W. J. Wanninger; and legislation, Mrs. Arthur A. Herald; as well as the platform of the American Medical Association, the resolutions adopted at the National Auxiliary's annual meeting, and short descriptions of nineteen books about medicine.

County officers and committee members will find a wealth of needed material in the *Bulletin*, issued four times a year. Send $1 for one year's subscription *now* to: Mrs. H. E. Christenberry, circulation manager, Highland Drive, Knoxville, Tennessee.

"DOCTORS AT WORK"

Arrangements have been made with the National Broadcasting Company for audiences to witness the broadcast of the forthcoming American Medical Association—National Broadcasting Company radio program DOCTORS AT WORK.

This program is in dramatic form, requiring ordinarily six actors; sound effects equipment and personnel; announcer, and orchestra. It is interesting to observe as well as to hear the broadcast of productions of this kind.

Physicians living in Chicago or vicinity, or contemplating visits to Chicago, may procure tickets to the broadcast by addressing a request, stating the date desired and a possible alternate date, to the Bureau of Health Education, 535 North Dearborn St., Chicago. Tickets are free. Ordinarily request should be limited to two tickets, but in special circumstances larger numbers may be available.

Programs are scheduled each Wednesday night, beginning November 13, at 9:30 p.m., central standard time, in the studios of Radio Station WENR, 19th floor, Merchandise Mart, Chicago. Visitors should be at the studio not later than 9:00 p.m.

Society Proceedings

Barron-Washburn-Sawyer-Burnett

The Barron–Washburn–Sawyer–Burnett County Medical Society met at the Land O' Lakes Hotel, Rice Lake, October 8, for dinner and a program dealing with tuberculosis. Drs. Earl E. Carpenter and Victor A. Lookanoff of the Middle River Sanatorium, Hawthorne, presented lectures on "Common Aims of the Sanatorium and the Family Physician in the Care of the Tuberculous Patient." Delegates to the State Medical Society meeting in Milwaukee in September reported to the group on transactions at the meeting. Eleven members and three guests attended.

Brown-Kewaunee-Door

A dinner, a business meeting, the presentation of reports of delegates to the recent State Society session and a scientific program,—those were events at the meeting of the Brown–Kewaunee–Door County Medical Society in Green Bay, October 10. Speakers on the scientific program were: Dr. Arthur Vorwahl, Saranac Lake, New York, whose subject was "Silicosis and Tuberculosilicosis; and Dr. Mary Allen, deputy health officer for the Green Bay District, who discussed the recent infantile paralysis epidemic in Wisconsin. Thirty attended.

Columbia-Marquette-Adams

The Columbia–Marquette–Adams County Medical Society met at St. Savior's Hospital, Portage, October 15. Dinner was served to the physicians and members of the woman's auxiliary. A business meeting was held and the following elected as officers for the coming year:

President—Dr. H. M. Caldwell, Columbus
President-elect—Dr. L. V. McNamara, Montello
Secretary-treasurer—Dr. C. J. Radl, Wisconsin Dells
Delegate—Dr. H. M. Caldwell
Alternate delegate—Dr. L. V. McNamara
Censors—Dr. R. B. Dryer, Poynette; Dr. L. V. McNamara, Dr. J. H. Houghton, Wisconsin Dells (chairman)

Dane

The Dane County Medical Society elected the following officers for the ensuing year, at its meeting in Madison, October 8:

President—Dr. Leo W. Peterson, Sun Prairie
President-elect—Dr. C. O. Vingom, Madison
Vice-president—Dr. Stanley Briggs, Madison
Secretary-treasurer—Dr. David L. Williams, Madison

Other features of the meeting, which was held at the Madison Club, were a special steak dinner, election of new members and the presentation of annual reports by officers and committees.

Dodge

The annual meeting of the Dodge County Medical Society was held at St. Joseph's Hospital, Beaver Dam, on October 17. The following officers were elected for the ensuing year:

President—Dr. A. J. Hebenstreit, Juneau
Vice-president—Dr. C. M. O'Hora, Beaver Dam
Secretary-treasurer—Dr. A. G. Hough, Beaver Dam
Censor—Dr. A. A. Hoyer, Beaver Dam
Delegate—Dr. A. G. Hough
Alternate delegate—Dr. A. A. Hoyer

Eau Claire-Dunn-Pepin

The Eau Claire–Dunn–Pepin County Medical Society met on September 30 in Eau Claire for dinner and a scientific meeting. Dr. Robert Burns, Madison, spoke on "Traumatic Backache." Forty-five attended.

Grant

The Grant County Medical Society met at the Municipal Building in Lancaster in October. Dr. R. G. Arveson, past-president of the State Medical Society, spoke at a dinner, served at 6 p. m. In an afternoon scientific session, Dr. Luther E. Holmgren, of the Jackson Clinic, Madison, discussed "Injection Treatment of Hernia;" Dr. Haddow M. Keith of the Mayo Clinic, Rochester, Minnesota, "Convulsions in Childhood;" and Dr. David S. Hillis of Northwestern University Medical School, Chicago, "Obstetrics." Twenty-nine attended the event.

Green Lake-Waushara

The Green Lake–Waushara County Medical Society met at the Bel-air Club in Green Lake on October 15. Dr. Garrett Cooper, Madison dermotologist, spoke on "Skin Diseases" in the scientific session which followed dinner, and Dr. Hart E. Van Riper, Madison, talked on "Care of the Premature Infant." Ten physicians attended the meeting.

La Crosse

The La Crosse County Medical Society held a business meeting in La Crosse on September 10 and on October 8 gathered to hear a lecture by Dr. Walter P. Blount, Milwaukee, on "Treatment of Compound Fractures."

Officers for the 1941 season were elected as follows:

President—Dr. M. W. Ward, Bangor
Vice-president—Dr. W. E. Bayley, La Crosse
Secretary-treasurer—Dr. S. A. Montgomery, La Crosse
Delegate—Dr. F. A. Douglas, La Crosse
Alternate delegate—Dr. Alf Gundersen, La Crosse
Censors—Dr. H. E. Wolf, La Crosse; Dr. J. P. Rosholt, La Crosse; Dr. E. H. Townsend, La Crosse

Sixty-two attended the meeting.

Manitowoc

The Manitowoc County Medical Society met at noon on September 12 at the Catholic Center, Manitowoc. Officers were elected for the next year, as follows:

President—Dr. T. H. Rees, Manitowoc
Vice-president—Dr. N. A. Bonner, Manitowoc
Secretary-treasurer—Dr. Theodore Teitgen, Manitowoc
Censors—Dr. J. M. Kelley, Cato; Dr. G. M. Hoffman, Manitowoc

At a noon meeting on October 17, attended by sixteen members, a report on the recent annual meeting of the State Medical Society in Milwaukee was presented.

Marathon

The Marathon County Medical Society met in Wausau, September 10, for dinner and a business meeting. Twenty-eight physicians attended. Dr. H. F. Martini, Wausau, was elected to membership in the society.

Milwaukee

The Medical Society of Milwaukee County met on October 11. Dr. A. A. Holbrook, Milwaukee, discussed "The Prophylactic Use of 'Cold Capsules,'" and Dr. F. A. Willius of the Mayo Clinic, Rochester, Minnesota, spoke on "Certain Considerations of Coronary Disease."

At its meeting on November 8, the society presented a program with Dr. E. D. Plass, professor of obstetrics and gynecology, State University of Iowa College of Medicine, Iowa City, as guest speaker. Dr. Plass spoke on "Advances in Obstetrics." Dr. M. M. Hipke, Milwaukee, was the speaker in a program feature entitled, "Fifteen Minutes of Preventive Medicine."

On November 12, Dr. Hans H. Reese, Madison, will present a lecture on "Recent Advances in Neuropsychiatry," the lecture being one of a series in a postgraduate course sponsored by the Society. Previous addresses in this series included "Recent Advances in Pathology of the Newborn," by Dr. William A. O'Brien, Minneapolis, and "Recent Advances in Internal Medicine," Dr. Frank B. Kelly, Chicago.

Oconto

The Oconto County Medical Society met at the Alamo Club, Stiles, October 22, at 8:30 p. m. Mr. Eldred Klauser of Stiles lead a discussion on a proposed plan for the medical care of indigents in Oconto county.

Outagamie

The Outagamie County Medical Society met at the Riverview Country Club, Appleton, for its annual golf jamboree and a scientific session. Dr. John O. Dieterle, Milwaukee, was the guest speaker; his subject was "Common Lesions of the Shoulder Joint." Twenty-two physicians competed in the golf tournament. Prizes were awarded to Drs. E. L. Bolton, E. H. Brooks, G. T. Hegner and F. J. Rankin —all of Appleton, and Dr. D. W. Curtin of Little Chute. Thirty-six attended the meeting.

Polk

The Polk County Medical Society met on September 26 at the Ike Walton Camp, Yellow Lake, Webster, Wisconsin. The members were guests of Dr. D. A. Maas. Dinner was served at 7 p. m. and then two physicians from Duluth, Minnesota, presented scientific papers; Dr. M. G. Gillespie discussed "Vitamin K in Liver Depletion," and Dr. E. L. Tuohy spoke on "Gout; A Forgotton Disease."

Portage

The Portage County Medical Society held its opening meeting of the 1940–1941 season at St. Michael's Hospital, Stevens Point, on October 16. A brief report of the major business transacted by the House of Delegates at the 99th anniversary meeting of the State Medical Society was given by Dr. A. G. Dunn, Stevens Point. Dr. Frank Iber, Stevens Point, discussed, "The Significance of Abdominal Pain," and Dr. R. W. Rice, Stevens Point, opened discussion of the paper. The guest speaker of the evening was Dr. Harold E. Marsh of the Jackson Clinic, Madison, whose topic was "Disturbances of Cardiac Rhythm."

Racine

The Racine County Medical Society met at the Elk's Club, Racine, on October 17. A business meeting was held, after a dinner, and the following program presented: "Laboratory Aspects of Diabetes," by Dr. Joseph Bock, Milwaukee; "The Acute Stage of Poliomyelitis," by Dr. Max Fox, Milwaukee.

Rock

The Rock County Medical Society met at the Hotel Hilton, Beloit, September 24. Dr. T. L. Squier, Milwaukee, was the guest speaker. His subject was "Allergic Rhinitis." Thirty-five attended the meeting.

On October 29 members of the society were guests of the superintendent and trustees of the

Rock County Hospital, Janesville. A group of physicians from the University of Iowa Medical School presented a scientific program: Dr. Wilbur R. Miller discussed "Psychoneuroses in General Practice," Dr. A. L. Sahs, "Diagnosis and Treatment of Neurosyphilis in General Practice," and Dr. S. C. Cullen, "Treatment of Barbiturate Poisoning."

Sauk

Twenty members of the Sauk County Medical Society attended the October meeting of the society in Reedsburg. Dr. R. E. Fitzgerald, Wauwatosa, the guest speaker of the evening, spoke on "Medicine and National Defense."

Sheboygan

The Sheboygan County Medical Society held its first meeting of the 1940–1941 season on October 24 at the Sheboygan Memorial Hospital. Several new members were introduced to the group and a scientific session was held. Dr. Herman Wirka, Madison, was the guest speaker.

Four new members were admitted to the society: Dr. V. F. Neu, Sheboygan; Dr. John Cary, Sheboygan; Dr. Carl Greenstein, Sheboygan and Dr. Milton Kuhs, Cascade. Thirty attended the meeting.

Trempealeau-Jackson-Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met in Arcadia on October 17. Dr. D. L. Emmett of the Mayo Clinic, Rochester, Minnesota, talked on "Diseases of the Prostate," in a scientific session. Fifteen members and two guests attended the meeting.

Walworth

The Walworth County Medical Society met in La Grange on October 10. "Cancer of the Skin" was the subject discussed by the guest speaker, Dr. M. Fernan–Nunez, Milwaukee. Another feature of the meeting was a demonstration of an iron lung. Twenty physicians and members of the woman's auxiliary attended the meeting.

Washington-Ozaukee

The Washington–Ozaukee County Medical Society met at Hilgen's Spring Park Pavilion in Cedarburg, September 12. The meeting was devoted to instructing delegates for the annual session of the House of Delegates in Milwaukee.

At a meeting on October 25, in Jackson, attended by twelve members, Dr. Milton Trautmann spoke on "Syphilis."

Waupaca

The Waupaca County Medical Society at its October meeting appointed a public relations committee to meet with the medical relief committee of the county board to discuss the medical care of indigents in the county.

Winnebago

The Winnebago County Medical Society met in Oshkosh at the Athearn Hotel, October 3. Dinner was served at 6:30 p. m. In a scientific session, Dr. William C. Keettel, Madison, addressed the group on "Latest Practical Developments in Obstetrics and Gynecology."

Central Neuropsychiatric Association

In accordance with a custom that its annual convention programs be conducted entirely by physicians in the convention city, the program of the 19th convention of the Central Neuropsychiatric Association, held in Milwaukee, October 25–26, was presented entirely by Milwaukee physicians. Among those who demonstrated clinical and research activities and facilities for neuropsychiatric care in Milwaukee to members of the Association from the central and western states, were the following: Drs. Rock Sleyster, Otto Foerster, F. R. Janney, V. J. Cordes, Max J. Fox, Gilbert J. Rich, Eben J. Carey, R. A. Jefferson, T. L. Squier, Norbert Enzer, E. Simonson, Lloyd H. Ziegler, J. A. Alston, C. W. Osgood, Michael Kasak, Harold Schroeder, J. L. Kinsey, A. I. Rosenberger, J. L. Garvey, E. L. Belknap, David Cleveland, M. G. Peterman, and Stephen S. Stack.

Interspersed between scientific sessions and demonstrations were luncheons, an evening banquet and a tour arranged for those interested in seeing how "what made Milwaukee famous" is made.

Central Wisconsin Society of Ophthalmology and Otolaryngology

Dr. G. L. McCormick, secretary of the Central Wisconsin Society of Ophthalmology and Otolaryngology, writes that the fall meeting of the society was held in Green Bay, September 28–29. He says:

"The meeting was one of the most interesting and profitable we have ever had. On Saturday afternoon there was a golf tournament at the Oneida Golf Club. There was a dinner at 6:30 p. m. at the Northland Hotel. Following this there were informal talks by Dr. Sanford Gifford of Chicago on injuries to the eye and by Dr. Francis Lederer of Chicago on the treatment of sinusitis.

"On Sunday the meeting began at 9 a. m. There were four formal papers presented:

" 'The Treatment of Glaucoma' by Dr. Sanford Gifford of Chicago.

" 'My Last Ten Cases of Retinal Detachment' by Dr. Peter C. Kronfeld of Chicago.

" 'The Management of Injuries of the Nose' by Dr. Samuel Salinger of Chicago.

" 'Evaluation of the Early Signs of Otogenic Complications with Special References to Management' by Dr. Francis L. Lederer of Chicago.

"Following the noon day luncheon a round table discussion was held. A number of questions had been mailed in by members of the society, and they were

answered by the guest speakers. Several hours were spent in this way.

"At the business meeting the following officers were elected:

President—Dr. J. V. May, Marinette
Vice-president—Dr. Donald Hugo, Oshkosh
Secretary-treasurer—Dr. G. L. McCormick, Marshfield

"It was decided to hold the next meeting at Wisconsin Rapids."

Milwaukee Neuropsychiatric Society

The Milwaukee Neuropsychiatric Society met jointly with the Wisconsin Society for Mental Hygiene on September 27 in the Pere Marquette Room of the Hotel Schroeder, Milwaukee. Guest speaker, Dr. Eric K. Clarke, director of the Psychiatric Clinic for Children, University of Minnesota, Minneapolis, gave an address on "Mental Hygiene in a Changing World."

Milwaukee Oto-Ophthalmic Society

The opening meeting of the 1940–1941 season of the Milwaukee Oto-Ophthalmic Society was held October 1 at the Milwaukee University Club. Clinical cases were discussed, dinner served at 6 p. m., and a scientific program presented, as follows: "Pulmonary Abscess Complicating Tonsillectomy," Dr. O. P. Schoofs; "Some Considerations on Refraction," Dr. Thomas McCormick; "Deafness in Children," Dr. Norman Fein; "Unusual Pathologic Aspects of 2,925 Consecutive Refractions," Dr. Edward Ryan.

Milwaukee Society of Clinical Surgery

The following program was presented by the Milwaukee Society of Clinical Surgery, at a dinner meeting at the University Club, 6:30 p. m., October 29: "Lipiodol Injection of the Bile Ducts," by Dr. Irving Cowan, and "Diagnosis and Therapy of Bone Tumors," by Dr. H. W. Hefke.

News Items and Personals

Friends and patients of *Dr. R. G. Arveson*, Frederic, held a "welcome back" commemorative dinner on Monday evening, October 21, following his duties as president of the State Medical Society of Wisconsin. Several friends, who had been in the community with him throughout his thirty-one years of practice, participated in the expression of the community's pleasure in his return to regular practice in the community, and in his continuance of community leadership and development.

Mr. J. G. Crownhart expressed to the people of Frederic and the surrounding territory the leadership and inspiration that Dr. Arveson brought to the Society during his term as president.

The facilities of the school auditorium in Frederic were overtaxed to accommodate the large number of friends who wished to be present. The auditorium of the school permitted the seating of 250 persons, but a like number were turned away because of limited facilities.

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Dr. Paul J. Trier, 1939 graduate of the University of Wisconsin Medical School, is now associated in practice with *Drs. S. E. Gavin* and *A. C. Florin*, Fond du Lac.

—△—

Dr. A. R. Remley has been appointed assistant superintendent of the Central State Hospital for the Criminal Insane at Waupun. Dr. Remley has been senior physician at the hospital since 1929.

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Dr. Stanley J. Seeger, Milwaukee, spoke on medical staff organization and professional relations and activities at the annual institute for hospital administrators held in Chicago recently, under the auspices of the University of Chicago. About 100 lay and professional hospital administrators attended the institute.

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Dr. John A. Schindler, Monroe, spoke at a regional meeting of the American College of Physicians in Rockford, Illinois, October 16. His subject was "The Importance of Various Symptomless Anomalies of the Gastrointestinal Tract." Among other Wisconsin speakers at the meeting were *Drs. E. L. Belknap*, Milwaukee, and *C. W. Osgood*, Wauwatosa.

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The 17th annual meeting of the North Central Section of the American Urological Association was held in Milwaukee, September 26–28. Milwaukee doctors on the arrangements committee included *Drs. S. J. Silbar, James C. Sargent* and *Walter M. Kearns*.

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The Jackson Clinic held its 16th annual postgraduate clinic, October 5. Among those taking part in the program were: Drs. Arnold S., James A., Reginald and Russell Jackson, Richard Phelps, Michael De Salvo, Harold E. Marsh, and John Gallagher, Madison; Drs. F. W. Madison, Eben J. Carey and James C. Sargent, Milwaukee. An innovation on the program was a talk on "The Relation of the Pharmacist and the Physician," by Mr. Oscar Rennebohm, Madison druggist.

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Dr. H. H. Christensen, Wausau, outlined advances in thoracic surgery at a recent meeting of the Rotary Club of Wausau.

Dr. Charles Skwor, Mishicot, past-president of the Manitowoc County Medical Society, has been elected president of the staff of two Manitowoc county hospitals,—the Holy Family Hospital in Manitowoc and the Two Rivers Municipal Hospital in Two Rivers.

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Dr. H. G. Mallow has been named health commissioner of Watertown to succeed Dr. Louis W. Nowack who recently resigned the position to report for a year of military duty at Camp Beauregard, Alexandria, La.

—△—

Dr. Leo M. Boxer, South Milwaukee, has been placed in command of Company B, 135th Medical Regiment, Wisconsin National Guard, one of the two medical companies recently formed in Racine.

—△—

Dr. W. C. Wojta, Fond du Lac, has been granted a leave of absence from his duties at the Wiley–Smith Clinic in order to pursue a course of study in diseases of the eye, ear, nose and throat at the University of Illinois.

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The 5th annual convention of the Wisconsin Association of Medical Technologists was held in Milwaukee, October 12–13. Nearly 100 Wisconsin medical technologists attended.

Dr. W. D. Stovall of the State Laboratory of Hygiene, Madison, was elected to honorary membership in the association for his work as a guide and teacher of medical technologists.

Among the program speakers were *Drs. Thomas J. Snodgrass*, Janesville, and *Norbert Enzer*, Milwaukee. Dr. Snodgrass spoke on "Sulfanilamide and Laboratory Observation," and Dr. Enzer on "Participation of the Medical Technologist in the Practice of Medicine." There were demonstrations and discussions of various laboratory procedures by the medical technologists.

Officers for the next year, elected at the meeting, are:

President—Louise Mead, Milwaukee

President-elect—Alice Thorngate, Madison

Secretary—(Mrs.) Elizabeth Kullmann, Milwaukee

Treasurer—Geralden Miller, Milwaukee

Historian—Laura Bates, Madison

Sergeant-at-Arms—(Mrs.) Leila Carson, Milwaukee

Directors—Fourth District, Elaine Beck, Marshfield; Sixth District, Sr. M. Corona Rohlik, La Crosse

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Sixty physicians attended the meeting of the Wisconsin Tuberculosis Society at Statesan, September 17. Out-of-state guests of the society were:

Dr. S. Job Lawes, Jr., S. Paulo, Brazil
Dr. G. A. Hedberg, Nopeming, Minnesota
Dr. Henry C. Sweany, Chicago, Ill.
Dr. A. G. Scherer, Chicago, Ill
Dr. Geo. L. Turner, Chicago, Ill.
Dr. L. L. Collins, Ottawa, Ill.

The society will hold its next meeting in the spring of 1941.

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Dr. Marvin F. Greiber has been appointed medical director of *Normandale*, Madison's private neuropsychiatric hospital. Dr. Greiber, who is a graduate of the University of Wisconsin Medical School, has recently returned from Kansas City, Missouri, where he spent a year at the Research Hospital.

Dr. Greiber will also be connected with the University of Wisconsin Medical School, as a member of the staff of the Wisconsin Psychiatric Institute.

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Dr. E. H. Pawsat recently completed a year's appointment to the Children's Medical Service of Bellevue Hospital, New York City, and has returned to Fond du Lac where he is associated in practice with *Drs. C. W. Leonard* and *S. A. Theisen.*

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Dr. A. L. Reinardy, recently of Burlington where he served as assistant to *Dr. L. O. Mastalir*, has entered the private practice of medicine in Union Grove.

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Dr. James A. Bach, Milwaukee, specialist in diseases of the eye, ear, nose and throat, celebrated his eightieth birthday on October 13. Joining in the celebration were his two sons, *Drs. Edwin and Mark Bach*, both of whom follow their father's specialty.

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Dr. Bjarne Ravn, Merrill, *Dr. Harold R. Fehland*, Wausau, and *Dr. Joseph F. Smith*, Wausau, were among those participating in the 8th annual meeting of the Wisconsin Society of X-ray Technicians, held in Wausau, October 4.

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Dr. P. F. Swindle, Milwaukee, was awarded first honors at the annual meeting of the American Academy of Ophthalmology and Otolaryngology in Cleveland recently, for his scientific exhibit relating to causes of the common cold.

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The Wisconsin Pharmaceutical Association held its 60th annual meeting in Milwaukee, October 10. Among the physician-speakers on the program was *Dr. William M. Jermain*, president of the Medical Society of Milwaukee County. Mr. Douglas E. Hunt, Wautoma, is president of the pharmaceutical association and Mr. Jennings Murphy, Milwaukee, is secretary.

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Dr. W. C. Reineking, superintendent and medical director of Lake View Sanatorium, Madison, attended the 27th annual Mississippi Valley Conference on Tuberculosis in St. Paul, October 2.

Physicians from fifteen counties gathered in Appleton on October 17 for the 2nd annual Fox River Valley Conference on Tuberculosis. Out-of-state speakers were Dr. C. K. Petter, head of Lake County Tuberculosis Sanatorium, Waukegan, Illinois, and Mr. C. W. Kammeier, executive secretary of the Iowa Tuberculosis Association.

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Two hundred and fifty-eight nurses registered at the convention of the Wisconsin State Nurses' Association in Eau Claire, September 30. Among the physician-speakers on the three-day program were *Dr. Joseph C. Baird*, Eau Claire, and *Dr. R. C. Buerki*, superintendent of Wisconsin General Hospital, Madison. Dr. Baird, as president of the Eau Claire–Dunn–Pepin County Medical Society, gave an address of welcome, and Dr. Buerki led a discussion on the relation of the public health nurse and the social worker.

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Dr. Arthur D. Bussey, Two Rivers, is taking a course in ophthalmology at the Research and Educational Hospital, University of Illinois, Chicago.

Coming Events

Clinics of the University of Wisconsin Medical School.—Physicians are welcome to attend these clinics, held on Saturdays from 11 a. m. to 12:30 p. m., in the main lecture room of the Service Memorial Institute, Madison. The clinic program for November and December is given below:

November 16:
Differential diagnosis and treatment of lymph node diseases—Dr. O. O. Meyer and associates

November 23:
Differential diagnosis and management of diseases of the hip joint—Dr. H. W. Wirka and associates.

November 30:
Present status of urinary antiseptics—Dr. Ira R. Sisk and associates.

December 7:
Clinical application of newer information relative to suprarenal dysfunction—Dr. E. S. Gordon and associates.

December 14:
Surgical treatment of diseases of the chest—Dr. J. W. Gale and associates.

Physicians are also invited to attend ward rounds, operating clinics, conferences and seminars, a detailed schedule of which may be obtained from the Dean of the Medical School.

Staff meetings are held bi-weekly during the academic year. At the meeting to be held November 19, sponsored by the Student Health Service, Dr. Llewellyn R. Cole, Madison, will speak on "Heart Disease as Found in 28,000 Students," and Dr. John E. Bentley, Madison, on "Athletic Injuries."

On November 26, to be designated "Hoyt–Dearholt Day" at the University, in honor of the late anti-tuberculosis leader, lectures will be given by Dr. Silas Evans of Ripon College, Dr. J. Burns Amberson of the Columbia University College of Physicians and Surgeons, and members of the staff of the Wisconsin Anti-Tuberculosis Association.

Tentative plans have been made for a lecture on November 22, at 8 p. m., at the meeting of the University of Wisconsin Medical Society, by the well-known neurologist, Dr. Tracy J. Putnam of New York City.

Clinics of Marquette School of Medicine.—Physicians throughout Wisconsin are cordially invited to attend these weekly clinics at the Milwaukee County Hospital, held every Friday from 10:30 a. m. to 12 noon. Subjects for discussion in November and December are:

November 15:
Traumatic lesions of the abdomen.
Genitourinary tuberculosis.

November 22:
Malignancies of the large bowel—
a. Significance of anatomical factors—Dr. Eben J. Carey, dean of the Marquette University Medical School.
b. Surgery of carcinoma of the large bowel.

December 6:
Acute abdominal emergencies.
Ruptured ectopic pregnancy.

December 13:
Hypertension; the management of early cases—Dr. George K. Fenn, associate professor of medicine, Northwestern University Medical School.
Treatment of burns.

December 20:
Edema and its management.
Blastomycosis and its surgical aspects.

Blue Book Number, Wisconsin Medical Journal: The Blue Book, containing digests of laws and information related to medical practice in Wisconsin, will be mailed to all members of the State Medical Society, December 10, 1940.

DEATHS

Dr. George H. Belding, Milwaukee, died at his home on September 15. He was 77 years of age.

A native of Caledonia, Minnesota, Dr. Belding was graduated from the University of Iowa dental school and practiced dentistry in Iowa for nine years before going to Milwaukee, where he attended the Milwaukee Medical College. After his graduation from the College in 1903, he practiced both as a dentist and physician.

He is survived by his widow and one daughter.

Dr. Henry G. Brueckbauer, Sheboygan, died September 16. He was born near Elkhart Lake in 1878. In 1904 he was graduated from the Homeopathic Medical College, St. Louis, Missouri. After spending two years in practice at Elkhart Lake, he opened an office in Sheboygan where he practiced until his death.

The doctor is survived by his widow and two sons.

Dr. P. A. Hoffmann, Campbellsport, died on August 29 after a long illness, at the age of 87 years.

Dr. Hoffmann practiced his profession in Campbellsport for 51 years, arriving in the village in 1888 in the midst of a scarlet fever epidemic, shortly after his graduation from the State University of Iowa College of Medicine. In May, 1938, when he completed 50 years in practice, a large civic celebration was held in his honor. He retired from active practice in 1939.

Dr. Hoffmann found relaxation from his work in music and not only organized and for many years conducted the Campbellsport band but played the organ in his church for a period of 50 years.

He is survived by his widow and two physician-sons—Dr. L. A. Hoffmann of Campbellsport and Dr. J. G. Hoffmann of Hartford. Another son, Dr. Mathias A. Hoffmann, was killed in an automobile accident in 1913, while responding to a sick call.

Dr. M. S. Hosmer, Ashland, a pioneer leader in the organized fight against tuberculosis in Wisconsin, died on September 22, at the age of 83 years.

Dr. Hosmer, a native of New Boston, Michigan, received his medical education at the University of Michigan Medical School, being graduated in 1882. He began his Ashland practice in 1886 and, with the exception of a year of postgraduate study in Vienna in 1894, remained in active practice in Ashland until September 19, 1940, a few days before his death.

Dr. Hosmer was generally recognized in northern Wisconsin as the leader of the movement which resulted in the establishment of Pureair Sanatorium at Salmo in 1920. At an institute held at that sanatorium, August 12, sponsored by the State Medical Society, the State Board of Health and the Wisconsin Anti-Tuberculosis Association, Dr. Hosmer's work against tuberculosis was reviewed and lauded; Dr. Fred G. Johnson, Iron River, was spokesman.

Dr. Hosmer was a member of the senior council of the Wisconsin Anti-Tuberculosis Association, a member of the Ashland–Bayfield–Iron County Medical Society and the American Medical Association and a life member of the State Medical Society of Wisconsin.

He is survived by one daughter and a son.

Dr. Melvin Maxam, Slinger, died of a heart attack August 25. He was 79 years of age.

The doctor was born in Warrensburg, New York. He attended the Milwaukee Medical College, Milwaukee, and was graduated in 1904. For a time he practiced in Stetsonville. In 1916 he opened an office in Slinger and continued to practice in that community for the remainder of his life.

Dr. Maxam was camp physician of the Modern Woodmen of America and health officer of the town of Polk. He is survived by his widow, a son and a daughter.

Dr. R. J. McDonald, Doylestown, died August 17 at a Columbus hospital where he had been under treatment since June. He was 69 years of age, and had practiced medicine continuously in Doylestown since 1901.

Dr. McDonald was born in 1871 on a farm near Fountain Prairie. After graduating from high school in Janesville he spent three years at St. Francis Seminary in Milwaukee studying for the priesthood. Later he attended University of Illinois College of Medicine, Chicago, and was graduated from the College in 1901. For many years Dr. McDonald was the Doylestown correspondent for a number of newspapers in Columbia county.

Dr. H. J. Niebauer, Madison, drowned in Lake Mendota on August 20. He was 31 years old.

The doctor was graduated in 1934 from the University of Wisconsin Medical School. Thereafter he practiced his profession in Iowa City, Iowa; Stevens Point, and Phillips, Wisconsin (his birthplace). On July 1, 1940, he accepted a position in the student health clinic of the University of Wisconsin.

Dr. Niebauer was a member of the State Medical Society of Wisconsin and the American Medical Association. He is survived by two daughters.

Dr. Rudolph C. Pfeil, Milwaukee, died October 3 after an illness of two months. He was born in Milwaukee in 1883 and was graduated from the Milwaukee Medical College in 1908.

The doctor started his practice in Mattoon, Wisconsin, in 1910. He moved to Thiensville in 1915. During the World War he enlisted in the medical corps. In 1919 he opened an office on Milwaukee's south side and practiced in that city until his death. He specialized in industrial surgery.

Dr. Pfeil was a member of the Medical Society of Milwaukee County and the State Medical Society of Wisconsin. He was a Fellow of the American Medical Association.

Surviving him are his widow, a daughter, and one son, who practices law in Milwaukee.

Dr. Theodore J. Redelings, pioneer Marinette physician, died September 4 in San Diego, California, after a long illness. He retired from active practice in May, 1937.

Dr. Redelings was elected to membership in the State Medical Society of Wisconsin in 1894. He served as president of the State Society in 1915 and in March, 1938, was elected to life membership. He was also a member of the Marinette–Florence County Medical Society and the American Medical Association.

The doctor was a graduate of Northwestern University Medical School, Chicago, class of 1887. He opened his Marinette practice immediately after his graduation and remained in that city for over half a century. In his early years in Marinette, during which time he served as city health officer, his practice is said to have necessitated trips as far west as Jim's Falls near Eau Claire, north to Escanaba, Michigan, and the territory around Goodman and Oconto Falls.

Shortly before leaving Marinette to move to San Diego, Dr. Redelings was honored at a large farewell dinner given by the Marinette Masonic Lodge of which he was a member for more than forty years. He is survived by his widow and one physician-son, Dr. L. H. Redelings of San Diego.

Dr. Edward S. Ryan, Sheboygan, died September 25 of a heart attack, suffered while he was visiting his sister in Milwaukee. He was 66 years of age.

The doctor was graduated from the Wisconsin College of Physicians and Surgeons, Milwaukee, in 1898, and later took postgraduate work in Chicago and New York. He began the practice of his profession in Greenleaf, Wisconsin. In 1902 he moved to Sheboygan and remained in practice there until his death. He specialized in the treatment of diseases of the eye, ear, nose and throat.

Dr. Ryan served with the medical corps during the World War. He was a member of the Sheboygan County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Dr. Rudolf F. Teschan, Milwaukee, died October 7 at his home of a heart attack. He was 63 years of age and had practiced his profession in Milwaukee for thirty-eight years.

Dr. Teschan was a graduate of the University of Illinois College of Medicine, receiving his medical degree in 1900. In the early days of his practice he was associated with his father, the late Dr. Rudolf C. Teschan; for the last eleven years he has practiced with his son, Dr. Rudolf A. Teschan.

The doctor was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

Dr. Fred A. Thayer, Beloit, died on September 5 of a heart ailment. He was 69 years of age and had practiced in Beloit for a period of thirty-seven years.

The doctor was born near Lake Mills. His family was among the early settlers of that region. Dr. Thayer taught school at Brillion and Chilton before taking up the study of medicine. He was graduated from the University of Illinois College of Medicine, Chicago, in 1903, and began the practice of his profession in Beloit shortly thereafter.

Dr. Thayer was a member of the Rock County Medical Society and the State Medical Society of Wisconsin. He was a Fellow of the American Medical Association. Surviving him are a physician-son —Dr. Richard A. Thayer of Beloit, and a daughter.

BIRTHS

A son, John Peter, Jr., to Dr. and Mrs. John Peter Malec, Madison, on September 11.

A daughter to Dr. and Mrs. M. F. Stricker, Middleton, on October 8.

A daughter to Dr. and Mrs. Judson Forman, Mt. Horeb, on September 15.

A daughter, Jeanette Ann, to Dr. and Mrs. R. E. Housner, Richland Center, on October 9.

A daughter, Arlene, to Dr. and Mrs. Arthur J. Macht, Madison, on September 20.

MARRIAGES

Dr. E. T. Rechlitz, Milltown, and Miss Doris Sylling, Amery, on September 24.

Dr. A. J. Hertzog, Eau Claire, and Miss Irma Behrens, Eau Claire, on October 11.

Dr. C. A. Vogel, Elroy, and Miss Ada E. Smith, Elroy, on September 14.

SOCIETY RECORDS

New Members

H. F. Martini, 605 Jefferson Street, Wausau.
H. J. Jeronimus, Jr., Osceola.
J. M. Pierpont, Montreal
J. R. Talbot, St. Joseph's Hospital, Marshfield.
C. S. Bloom, 232½ East Lake Street, Horicon.

Changes in Address

A. L. Reinardy, Burlington, to Union Grove.

Ruth E. Church, Ashland, to 50 Haven Avenue, New York, New York.

C. F. Rosenberg, Waupaca, to 15 East Gorham Street, Madison.

Arthur Bussey, Two Rivers, to 4811 North Bell Street, Chicago, Illinois.

E. R. Krumbiegel, Milwaukee, to 430 North Lincoln Avenue, Beaver Dam.

W. C. Wojta, Fond du Lac, to 1804 Congress Street, Chicago, Illinois.

See page 989 for Index to Advertisers. Many Journal advertisers offer valuable samples,—all offer valuable information.

CORRESPONDENCE

"ALONG THE BURMA ROAD . . ."

BOARD OF FOREIGN MISSIONS OF THE METHODIST EPISCOPAL CHURCH
150 Fifth Avenue, New York, N. Y.

October 21, 1940.

The Editor,
Wisconsin Medical Journal,
Madison, Wisconsin.

Dear Editor: I am sure all your readers will be interested in the experiences of S. H. Liljestrand, M.D., missionary of the Methodist Church in Chengtu, West China, along the Burma Road, and perhaps one or more readers may be interested in giving aid to his Hospital. Dr. Liljestrand (M.D., Syracuse, 1915) is a native of Jordan, N. Y. and has been in China since 1916.

The Women's Hospital, connected with West China University, Chengtu, was completely destroyed in a fire which followed a Japanese air-raid in August.

"The fire which destroyed the Women's Hospital destroyed all of my cystoscopic and electrotherapeutic apparatus and the accessories of a general gynecological clinic," writes Dr. Liljestrand. "Fortunately I had loaned a cystoscope to the Men's Hospital a block away. Also, the radium was saved, being in a patient that night. The patient was ambulatory. She went to a Chinese hotel because of the fire. In the morning, her honorable husband informed us of her whereabouts and the radium was recovered! I still have only fifty milligrams—but that is a mighty help.

"I lost a diathermy machine; an ultra-violet lamp, large size; three adult-size cystoscopes; one infant's and one children's cystoscope galvanic electrical apparatus.

"The fire also destroyed our medical periodicals—including those on urology, surgery, gynecology, and obstetrics . . .

"I would be very glad if we could get second-hand apparatus, and used copies of medical magazines . . . There continues to be great demand for our services in this war-torn section of China."

If any of your readers are interested in assisting Dr. Liljestrand with used but good conditioned material, will they please communicate with the Medical Department Board of Foreign Missions, Methodist Church, 150 Fifth Avenue, New York City.

I trust you will be able to call this matter to your readers' attention. It will be greatly appreciated.

Sincerely yours,

WILLIAM W. REID.

POLITICAL MEDICINE

October 1, 1940.

Mr. J. G. Crownhart, Secretary,
State Medical Society,
Madison, Wisconsin.

Dear Mr. Crownhart: The attached squib is a concise way of expressing exactly what the different forms of socialized insurance mean, and it is expressed in such a way that everybody, both in the profession and among the laity can understand it.

I would appreciate very much having it appear in the next issue of The Journal for the benefit of the membership as a whole.

Attention—Medical Profession

Suggest substituting the term "Political Medicine" for the terms "Federal," "State" or "Socialized Medicine" henceforth in all medical papers, speeches and all publicity pertaining in any way to this subject. It will throw the issue squarely into the laps of the politicians where it belongs and where it originated. It may not prove so easy for the politicians to explain to the public just why it should be necessary to force politics between the "Patient and his Physician."

Also, the use of the term "Political Medicine" is a clear and simple explanation to those persons who are "in the dark" as to the true meaning of "Socialized Medicine."

JOHN W. HANSEN, M. D.,
531 W. Wisconsin Ave.,
Milwaukee, Wis.

REPRINTS WANTED

War Department
ARMY MEDICAL LIBRARY
Washington, D. C.

October 22, 1940.

Editor,
Wisconsin Medical Journal,
Madison, Wis.

Sir: I am directed by the Surgeon General to inform you that authors' reprints are gratefully received at the Army Medical Library. They are placed in a special collection catalogued by author and thus form a ready bibliography of the work of any given writer and a valuable supplementary source of material when the volume of original publication is temporarily unavailable at the bindery or on loan.

Very respectfully,

HAROLD W. JONES,
Colonel, Medical Corps, United States Army.

Medical Examiners Appointed

Dr. O. R. Lillie, Milwaukee, was appointed by Governor Julius P. Heil, in October, to be chief medical director in the administration of the selective service law in Wisconsin. Medical examiners for the several draft boards, as announced by the governor, follow:

Adams—G. F. Treadwell, Friendship
Ashland—Wm. J. Tucker, Ashland
Barron—C. C. Post, Barron
Bayfield—A. C. Taylor, Washburn
Brown—E. S. Knox, Green Bay; F. J. Gosin, Green Bay; J. P. Lenfestey, De Pere
Buffalo—B. F. Johnson, Mondovi
Burnett—Clarence L. Treadwell, Siren
Calumet—N. J. Knauf, Chilton
Chippewa—J. A. Kelly, Chippewa Falls; Herbert M. Trankle, Bloomer
Clark—H. H. Christofferson, Colby
Columbia—C. W. Henney, Portage
Crawford—C. A. Armstrong, Prairie du Chien
Dane—Michael Coluccy, Madison; C. O. Vingom, Madison; Harry A. Keenan, Stoughton; James P. Dean, Madison
Dodge—E. P. Webb, Beaver Dam; P. F. Langenfeld, Theresa
Door—F. C. Huff, Sturgeon Bay
Douglas—H. J. Orchard, Superior; J. H. Weisberg, Superior
Dunn—I. V. Grannis, Menomonie
Eau Claire—E. L. Mason, Eau Claire; Herman Prill, Augusta
Fond du Lac—D. J. Twohig, Fond du Lac; O. F. Guenther, Campbellsport
Florence—Francis DeSalvo, Niagara
Forest—Hector Marsh, Crandon
Grant—R. C. Godfrey, Lancaster; C. M. Schuldt, Platteville
Green—L. A. Moore, Monroe
Green Lake—A. J. Wiesender, Berlin
Iowa—H. D. Ludden, Mineral Point
Iron—M. J. Bonacci, Hurley
Jackson—Irwin K. Krohn, Black River Falls
Jefferson—G. E. Eck, Lakemills; H. O. Caswell, Fort Atkinson
Juneau—A. R. Kaufman, Mauston
Kenosha—C. H. Gephardt, Kenosha; F. D. Curtiss, Kenosha; J. H. Cleary, Kenosha
Kewaunee—D. B. Dana, Kewaunee
La Crosse—E. E. Gallagher, La Crosse; George Skemp, La Crosse
LaFayette—H. F. Hoesley, Shullsburg
Langlade—C. E. Zellmer, Antigo
Lincoln—Bjarne Ravn, Merrill
Manitowoc—Arthur Teitgen, Manitowoc; L. J. Moriarty, Two Rivers
Marathon—Jesse R. Bryant, Wausau; J. A. Jackson, Mosinee; L. M. Pearson, Wausau
Marinette—J. W. Boren, Marinette
Monroe—C. S. Phalen, Sparta
Oconto—W. C. Watkins, Oconto
Oneida—C. A. Richards, Rhinelander
Outagamie—Earle F. McGrath, Appleton; G. J. Flanagan, Kaukauna; G. M. LaCroix, Shiocton
Ozaukee—O. J. Hurth, Cedarburg
Pepin—G. E. Bryant, Pepin
Pierce—C. A. Dawson, River Falls
Polk—L. O. Simenstad, Osceola
Portage—M. G. Rice, Stevens Point
Price—H. B. Norviel, Phillips
Racine—R. D. Jamieson, Racine; F. W. Pope, Racine; G. L. Ross, Racine; J. F. Bennett, Burlington
Richland—Gideon H. Benson, Richland Center
Rock—S. A. Freitag, Janesville; Willard Sumner, Edgerton; Geo. W. John, Beloit
Rusk—Woodruff Smith, Ladysmith
St. Croix—J. W. Livingstone, Hudson
Sauk—A. C. Edwards, Baraboo
Sawyer—E. H. Dufour, Hayward
Shawano—Carl Stubenvoll, Shawano
Sheboygan—Charles Maercklein, Sheboygan; T. J. Gunther, Sheboygan; A. C. Radloff, Plymouth
Taylor—L. E. Nystrum, Medford
Trempealeau—R. N. Leasum, Osseo
Vernon—R. S. Hirsch, Viroqua
Vilas—O. R. McMurry, Eagle River
Walworth—D. H. Jeffers, Lake Geneva
Washburn—E. R. Hering, Shell Lake
Washington—S. J. Driessel, Barton
Waukesha—F. J. Woodhead, Waukesha; J. F. Wilkinson, Oconomowoc
Waupaca—A. M. Christofferson, Waupaca
Waushara—G. L. Karnopp, Wautoma
Winnebago—W. N. Linn, Oshkosh; E. B. Pfefferkorn, Oshkosh
Wood—F. X. Pomainville, Wisconsin Rapids; L. A. Copps, Marshfield

Milwaukee County—
- First Ward—G. F. A. Fitzgerald
- Second Ward—A. M. Bodden
- Third Ward—Charles Fidler
- Fourth Ward—C. J. Crottier
- Fifth Ward—Joseph Lettenberger
- Sixth Ward—Edward Jackson
- Seventh Ward—C. H. Baumgart
- Eighth Ward—E. L. Baum
- Ninth Ward—G. E. Collentine
- Tenth Ward—J. A. Heraty
- Eleventh Ward—H. J. Gramling
- Twelfth Ward—A. A. Krygier
- Thirteenth Ward—L. L. Allen
- Fourteenth Ward—W. P. Zmyslony
- Fifteenth Ward—H. J. Cannon
- Sixteenth Ward—Dirk Bruins
- Seventeenth Ward—E. X. Thompson
- Eighteenth Ward—Oscar E. Lademan
- Nineteenth Ward—W. F. Grotjan
- Twentieth Ward—E. L. Bernhart
- Twenty-first Ward—Albert Popp
- Twenty-second Ward—E. F. Barta
- Twenty-third Ward—P. L. Callan
- Twenty-fourth Ward—E. A. Brzezinski
- Twenty-fifth Ward—Theodore D. Watry
- Twenty-sixth Ward—J. A. Froelich
- Twenty-seventh Ward—J. J. Adamkiewicz
- West Allis, wards 2, 3, and 4—R. H. Frederick
- West Allis, ward 1; West Milwaukee, Franklin and Greenfield Towns—E. D. Wilkinson
- Cudahy and Town of Lake—Bernard Krueger
- South Milwaukee and Towns of Oak Creek and Franklin—George Dempsey
- Whitefish Bay, Shorewood, Fox Point and Towns of Granville and Milwaukee—J. S. Gordon
- Wauwatosa and Town of Wauwatosa—E. J. Carey

Milwaukee Serum Center Products Available to Wisconsin Physicians

The Milwaukee Serum Center has been preparing blood plasma for immediate use for several years. At the present time, normal human serum and plasma are being prepared and stored for intravenous use in such conditions as shock, burns, nephrosis and hypoproteinemia. Likewise, concentrated human serum has been prepared which can be used to replenish blood proteins, to promote diuresis, as a hypertonic solution to decrease intracranial pressure, and in shock. This product (four times concentrated) is the one which the Canadians have prepared and shipped in large quantities to England for the treatment of shock during the present war.

The Milwaukee Serum Center has been in existence over five years, and has operated at Columbia Hospital as a nonprofit organization to prepare and dispense human convalescent serum as well as normal human serum and plasma.

During the five-year period, 2,409 collections of blood have been made, equalling 547 liters. The Center is licensed and its products approved by the National Institute of Public Health.

Scarlet fever convalescent serum has been used with good results in both the prevention (10 days) and treatment of the disease. Many cases of miscellaneous hemolytic streptococcic infections (e. g. surgical scarlet fever) have responded to treatment by this agent.

Convalescent measles serum has been used to prevent and modify measles in young children with good results. Modified measles still prevents the recurrence of measles in later life.

Mumps, chicken pox and poliomyelitis convalescent serums have also been used with varying results. Hyperimmune whooping cough serum is now being prepared. Excellent results have been reported with its use.

The products described above are available to physicians throughout the state. Arrangements have been made with transportation companies for rapid delivery.

The Milwaukee Serum Center address is as follows:

Milwaukee Serum Center
Columbia Hospital
3321 North Maryland Avenue
Milwaukee, Wisconsin
Telephone: Edgewood 0480

Minutes of the Council; Milwaukee, September 16, 1940

1. Call to Order

The Council was called to order at 2:30 p. m., Tuesday, September 16, at the Schroeder Hotel, Milwaukee.

2. Roll Call

The following were present, constituting a quorum: Councilors Gavin, Christofferson, Krahn, Blumenthal, Pippin, Johnson, Heidner, Clark, Pechous, Butler and Gramling, President Arveson, President-Elect Sproule, Past-President Rector, Treasurer Ira Sisk, Vice-Speaker Kurten, Secretary Crownhart and Assistant Secretary Larson.

3. Introduction of Guests

Others attending the meeting were Drs. B. S. Adams and B. J. Branton, president and president elect of the Minnesota State Medical Association. Councilor Pippin presented as a guest Mr. B. L. Marcus, president of Wisconsin Small Employers, Inc., who addressed the Council briefly.

4. Report of Auditing Committee

Dr. Christofferson reported to the Council the work of the Auditing Committee, stating that the committee had reviewed all vouchers upon which disbursements were authorized and found them to correspond with the secretary's and the treasurer's account books; and also actually reviewed the bonds held by the Society in safekeeping at the First National Bank, Madison. The report given by Dr. Christofferson as chairman of the Auditing Committee follows:

Report of the Auditing Committee of the Council

This committee is composed of Drs. H. H. Christofferson, chairman; George W. Krahn, and Robert W. Blumenthal. All three members of the committee received the report of the auditor of the Society as relates to: (1) the secretary's receipts and disbursements as secretary; (2) the treasurer's account; (3) the accounts of the Wisconsin Medical Journal.

Subsequently the committee met in the office of the Society (Dr. Blumenthal was unable to attend) and spent the day.

The committee has examined the auditor's report and finds the books to be in excellent condition, the treasurer's books being balanced and vouchers all in order. An examination was made of the individual itemized vouchers for the complete year of 1939. We find vouchers for bills paid had been issued according to the authority vested in the secretary by the Council.

During the calendar year the income of the Society from membership was as follows:

1. 2363 "full-pay" members	$54,625.00
2. 10 "partial-pay" members	167.55
3. 40 new members for whom dues were prorated	214.20
4. A dividend check to apply on a County Society remittance of 1932 which was involved in a bank closure	17.17
5. Dues from members delinquent in 1938 and earlier years	890.40
	$55,914.32

The secretary makes periodical remittances to the treasurer of all cash received from whatsoever source. At no time does the secretary have in any account an amount that is in excess of the limit insured by the Federal Government.

Even petty cash amounts are handled by check with an accounting and we feel that safeguards to the Society in the handling of their moneys are well established.

THE AUDITING COMMITTEE OF THE COUNCIL.

It was moved by Clark–Heidner that the report of the Auditing Committee be accepted. Treasurer Sisk discussed the report of the Auditing Committee to advise that the cash on hand of $3,257.23 did not represent actual working capital, but stated that approximately $3,100 of this amount represented sale of bonds which, at the end of 1939, had not been reinvested. He said that the balance remaining from the 1939 funds was approximately $61. The Clark–Heidner motion approving the report of the Auditing Committee was then unanimously carried.

5. Confirmation of Mail Ballot

The secretary stated that he wished to place before the Council the matter of the confirmation of the mail ballot on the question of the position of the Society concerning hospital insurance which had been formulated by the Executive Committee of the Council and which had been circulated to the councilors on August 9. It was moved by Gramling–Rector that the mailed report as sent to the delegates incorporating the position of the Council, and previously forwarded to the councilors, stood approved as the position of the Council. Carried unanimously.

6. Discussion of Cult Practices

General discussion followed concerning cult practices and licensure laws.

7. Report on M-Day Committee

The secretary discussed the relationship of the physician in mobilization and reported on the activities of the M-Day Committee. He stated that the data relating to the physician under mobilization were changing day by day, but that present indications were that the drain upon Wisconsin physicians would not be so extensive as was originally anticipated. He further stated that it was the present intent of the army officials to employ contract surgeons in and around the cantonment areas, with resultant lightening of the need for regular army physicians. The relationship of the M-Day Committee to the Adjutant General's office and the close spirit of cooperation was pointed out. Both the needs of the army and civilian population will be taken into simultaneous consideration when demands are made for military physicians, and every effort will be made to avoid the disastrous condition wherein civilian needs are stripped in order to serve military medical needs. The secretary advised that this procedure would be carried out under strict formula in order that the personal element would not be a factor. He stated further that undoubtedly students and interns would receive a deferred status.

The members of the Council discussed the status of army contract surgeons with regard to war risk insurance, service connected disabilities, pensions, etc. Some councilors felt that a study should be made of this question and members taking government contracts be advised as to their rights, privileges, etc. as contract surgeons. The members having before them complete information as to their responsibilities and privileges, could make their individual decisions as to whether they wished to enter the service as regular army officers or as contract surgeons.

8. Open Panel Listing

The Council considered the question of open panel listing as regards the listing of specialists. The secretary advised that in the past there have been numerous requests by those limiting their practice to one of the specialties for inclusion on the panel of such specialties as dermatology, orthopedics, internal medicine, radiology, etc. After discussion the Council instructed the secretary to prepare future panels under the same conditions and rules as have prevailed in the past. However, the Council asked that a special editorial be contained in the Wisconsin Medical Journal relative to the referral of cases to specialists early in the course of the injury or the disease. Whenever specialist care might be indicated, it was recommended that it be emphasized that the family physician make such references early. A further suggestion was made that the State Medical Society furnish to insurance companies lists of consultants available as represented by their specialties.

9. Presentation of Guests—Adams and Branton

Drs. Adams and Branton, president and president-elect of the Minnesota State Medical Association, were called upon by the chairman of the Council to address the Council briefly.

10. Executive Sessions of the House of Delegates

The secretary placed before the Council the suggestion that all sessions of the 1941 House of Delegates be made executive sessions. The Council concurred in this suggestion. The Council discussed the resolution received by the President from Associated Hospital Service, Inc., wherein it was asked that the House of Delegates endorse their plan. It was recommended that this resolution be placed before the House of Delegates in the usual order of business.

11. Adjournment

The meeting adjourned at 4:30 p. m.

J. G. CROWNHART,
Secretary.

Approved:

S. E. GAVIN, M. D.,
Chairman of the Council.

Significance of the New Federal Food, Drug, and Cosmetic Act

By THEODORE G. KLUMPP, M. D.
Chief, Drug Division, U. S. Food and Drug Administration
Washington, D. C.

ON JUNE 25, 1938, the Federal Food, Drug, and Cosmetic Act was enacted into law. On that date, the sections pertaining to new drugs, dangerous drugs, and injurious cosmetics became effective. Other provisions became operative only to the extent that they may relate to the enforcement of the aforementioned sections. The Act was to have become effective in its entirety on June 25, 1939, but meanwhile an amendment was enacted postponing the new labeling requirements until January 1, 1940, or six months later under certain conditions. The new law then became fully operative on July 1, 1940. The administration of this law was delegated to the Food and Drug Administration. The Food and Drug Administration is a small organization. It has had, however, a continuity of service in administering the law of the land on food and drugs since 1906. Its employes, from the Commissioner of Food and Drugs down, are in the civil service. The organization was recently transferred from the Department of Agriculture to the Federal Security Agency which, with the Public Health Service and other public health and welfare units, is perhaps a more natural habitat for our work.

Before the passage of this Act, we were being protected against the hazards that we face in foods and drugs by the Food and Drugs Act of 1906. This old law was passed before the cosmetic industry had become important, so, of course, nothing was said about cosmetics in it. It provided no control over interstate traffic in dangerous or new drugs or therapeutic devices. In the passage of the Food, Drug, and Cosmetic Act, the philosophy of Congress was quite definitely to protect the public health at every stage in the traffic in food, drugs, and cosmetics; to guarantee comprehensive information to the consuming public as to the character and composition of foods and drugs; to protect consumers against deception; to facilitate enforcement operations by removing some of the legislative handicaps of the earlier law, and to impose such penalties as will constitute genuine restrictions against violations of the statute.

Many provisions of the Act are of particular interest to physicians. The sections proscribing dangerous drugs and devices and injurious cosmetics, and effecting more stringent control over deleterious ingredients in foods, should bring about a lower general incidence of poisoning or injury from these sources. It may be anticipated that the provisions which require disclosure of the active ingredients of drugs, adequate directions for use and warnings will aid the public in making more intelligent purchase and use of drugs. Similarly, the physician will be in a position to know the nature of the medications taken by his patients. While Congress recognized self-medication, its purpose was to make the self-administration of drugs safe and free from deception.

Two Major Prohibitions

The Food, Drug, and Cosmetic Act contains two major prohibitions in regard to drugs and therapeutic devices.

Adulteration.—It provides, among other things, that a drug or device is adulterated if its strength differs from, or if its purity or quality falls below, that which it purports or is represented to possess. At first glance, this language appears a little strange when applied to therapeutic devices or contrivances; but under it we feel that we may proceed against an ultraviolet lamp that gives off only inconsequential amounts of ultraviolet radiation, clinical thermometers that fail to give accurate temperature readings, ozone generators that fail to generate ozone, and others.

Misbranding.—The second major prohibition contained in the Act is against misbranding and under this is a broad subsection which declares a drug or device to be misbranded if its labeling is false or misleading in any particular. This was intended to embrace therapeutic representations as well as other labeling material that might be false or misleading. In addition to other general provisions under this section, the law declares a drug or device to be misbranded unless its labeling bears adequate directions for use and adequate warnings. The responsibility for preparing adequate directions for use and adequate warnings has been placed by Congress upon the manufacturer. However, in order to be helpful and perhaps *to serve as a guide*, the Food and Drug Administration has made known a few sample warning statements which have not been subject to adverse criticism. As examples of these, the following may be mentioned:

1. **Cathartic or laxative drugs** (except castor oil and phenolphthalein) which act as irritants to the gastrointestinal tract or stimulate intestinal peristalsis:

   "*Warning:* Not to be used when abdominal pain (stomach-ache, cramps, colic) nausea, vomiting (stomach sickness) or other symptoms of appendicitis are present.

   "Frequent or continued use of this preparation may result in dependence on laxatives."

2. **Preparations containing sodium perborate as an active ingredient and intended for local use in the mouth and throat:**

   "*Warning:* This preparation may cause irritation and inflammation of the gums, tongue, and mucous membranes of the mouth. It should be discontinued at the first sign of irritation or soreness. In case of doubt, consult your physician or dentist."

3. **Atropine and pharmacologically related drugs:**

   "*Caution:* Frequent or continued use of this preparation should be avoided. Discontinue if dryness of the throat, excessively rapid pulse or blurring of vision appears. Warning: This preparation should not be taken by elderly people except on competent advice."

4. **Acetophenetidin:**

   "*Warning:* Frequent or continued use may be dangerous, causing serious blood disturbances. Do not take more than the dosage recommended."

5. **Preparations containing silver salts:**

   "*Caution:* Prolonged or frequent use of this preparation may result in permanent discoloration of the skin and mucous membranes."

The complete list of such warning statements may be obtained by interested physicians by writing to the Food and Drug Administration, Washington, D. C.

The law also declares a drug to be misbranded if it is dangerous to health when used in the dosage or with the frequency or duration prescribed, recommended, or suggested in the labeling thereof. Under this provision, the Administration has already taken action against 101 shipments of drugs and sixty-four shipments of devices in addition to numerous actions against cosmetics found to contain deleterious ingredients which might render them injurious to health. In addition, the Food and Drug Administration has issued announcements, declaring that the indiscriminate distribution of such drugs as cinchophen, neocinchophen, aminopyrine, sulfanilamide, and related drugs, is contrary to law. The purpose of these announcements was to restrict the use of these potentially dangerous drugs to the prescription or direction of a physician.

These announcements and legal actions that have been taken to support them have eliminated from interstate commerce practically all the proprietary preparations containing such drugs as ingredients. The bootleg, over-the-counter, sale of these drugs, principally as pharmaceuticals in response to a specific request for the article by name, or its distribution as a part of over-counter prescribing by the druggist, has also been sharply curtailed. However, the policing of the retail distribution of drugs is principally a function for local, state, and municipal authorities. The Food and Drug Administration does not have the facilities to cover the vast number of retail outlets throughout the country. The extent to which such clandestine distribution can ultimately be completely eliminated is dependent principally upon the voluntary cooperation which we receive from the retail distributors and the local enforcement agencies. The following is a sample of the type of notice distributed:

To Distributors of Cinchophen, Neocinchophen, and Related Drugs:

Since the introduction of cinchophen as a therapeutic agent some 30 years ago, many reports of its toxic manifestations have been reported in medical literature. These include numerous cases of acute yellow atrophy and cirrhosis of the liver which result in permanent damage and not infrequently in death. The dangerous potentialities of this drug are now generally recognized by informed physicians.

The toxic properties of neocinchophen are generally similar to those of cinchophen.

In the light of these facts, careful consideration has been given to the status of cinchophen and neocinchophen under the currently effective provisions of the Food, Drug, and Cosmetic Act which deal with traffic in dangerous drugs.

In the opinion of the Food and Drug Administration, cinchophen, neocinchophen, and drug preparations containing them, when found in interstate commerce under labeling which may result in their use by the general public, are actionable under Section 502(j) of the Federal Food, Drug, and Cosmetic Act.

Very truly yours,
W. G. Campbell, *Chief.*

New Drugs

Of particular importance is the protection provided by the Act in section 505 against the marketing of new drugs which have not been adequately tested for safety. The provisions of that section cast upon the applicant the duty of demonstrating by adequate investigations the safety of the drug with respect to which the application is filed. The law does not leave to the realm of doubt that which can be demonstrated by scientific means. Applicants are expected to make use of all reasonable means of investigation. The goal should be a demonstration of the safety of the drug, not merely the accumulation, through superficial investigations, of data which the applicant hopes will be sufficient to secure the effectiveness of the application. Determinations of safety made under section 505 must be made in relation to use under the conditions prescribed, recommended, or suggested in the proposed labeling of the drug.

It should be noted that the new drug provisions of the law relate only to the safety of the drug. The law does not authorize enforcement officials to refuse to permit a drug to be marketed solely on the basis of lack of therapeutic merit, or because of representations made for it. This is a point which has not been fully appreciated by physicians, judging from some of the comments that have been received concerning certain new drugs.

Since the provisions relating to new drugs became effective on June 25, 1938, more than 3,000 new drug applications have been received. Among these have been applications for such drugs as sulfapyridine, desoxycortecosterone, stilboestrol, vitamin K preparations, and sulfathiazol. Physicians are in position to appreciate the grave responsibility which this places upon the Food and Drug Administration as well as the burden which it lays upon the limited facilities made available for the task. It cannot be emphasized too strongly that it would be impossible to provide the protection which the public should receive from this section of the law without the whole-hearted support of the medical profession.

From our experiences with new drug applications to date, it is evident that some drug manufacturers are not unwilling to exploit members of the medical profession to obtain from them clinical data which the manufacturer can present in support of his new drug application. If the public as well as the profession is to have the fullest protection from this section of the Act, physicians must not assume lightly their responsibilities in this connection. Above all, they must avoid lending their names and endorsements to new and untried drugs merely as a gesture of encouragement. If they are not experts in the fullest sense of the word in the evaluation of the safety of a drug, or they do not have available adequate facilities for making all the necessary clinical and laboratory tests under carefully controlled conditions, they are doing the manufacturer and the public a disservice by undertaking an inconclusive study. They should leave the evaluation of such delicate and vital problems, as the safety of drugs, to those who by specialized training and experience and facilities are truly qualified as experts. Those who have a genuine basis for being considered experts will do society a great wrong if they fail to make thorough, well-controlled clinical studies with drugs before expressing an opinion. Catastrophes

such as the elixir of sulfanilamide episode should forever stand as a warning against a careless attitude toward new and untried drugs.

Limitations of Act

The Food, Drug, and Cosmetic Act does not contain jurisdiction over advertising. This comes under the Federal Trade Commission Act. The Food, Drug, and Cosmetic Act is also not designed to regulate the practice of medicine or any of the healing arts. In my opinion, we will probably not be able to touch those cultists, faddists, and others who lay claim to be practicing one of the healing arts. The regulation of these lies within the jurisdiction of the states and municipalities. However, the law impinges upon this field and I can assure you that we will go as far as the courts permit us in extending the protection of the Federal Food, Drug, and Cosmetic Act to the general welfare. In the discharge of our duties in the enforcement of the Act, we have had an unusual opportunity to see the operations of cultists, faddists, and quacks of various kinds. In my judgment, these ignorant, or misguided, or dishonest cultists are a serious menace to the public health. Not infrequently they employ expensive devices, both diagnostic and therapeutic, to impress those who have been attracted by their gold-brick promises of cure. In other situations, we find practitioners of various so-called healing arts who have been licensed to practice their arts by state legislatures stepping out beyond the bounds of their authorized sphere. They employ such devices as x-ray machines, endothermy, diathermy, cautery, and other devices for which we all recognize special training and skill are necessary. The situation is serious. Many states appear to have very little interest and practically no machinery or appropriation properly to enforce their various medical practice acts. In some states the legislatures appear to be duped by the representations of these quacks. Responsible groups of physicians must take a more active and aggressive lead in opposing these parasites. In these matters, laymen do not even know when they are victimized and exploited. I cannot escape the conviction that, as physicians, we have been too busy with our everyday duties to take full advantage of our opportunities to educate the public and thus, in the long run, lighten our own tasks. No one is in better position than the qualified physicians of this country to sponsor legislation to protect the public. It is up to them to oppose vigorously the enactment of state laws that are not in the public interest in this field and, above all, our medical societies should bear down on the enforcement agencies to see to it that the quacks are prosecuted and give their full cooperation once such actions are begun.

Some Accomplishments Under the Act

As mentioned previously, the sections of the law relating to dangerous drugs and devices and to cosmetics containing deleterious ingredients that may render them injurious to health, and the new drug section of the Act, became effective in June, 1938. It may be of interest to note what has been accomplished under these provisions of the Act and those which became partially effective on January 1, 1940, in the two-year interval from July, 1938, to July, 1940. During this time, there were a total of 1,395 actions against foods, 339 cases against drugs, 242 cases against devices, and 169 cases against cosmetics.

Action against drugs.—Of the 339 drug cases, seventy were seizures of dangerous drugs. These included actions against preparations containing aminopyrine, cinchophen, barbituric acid derivatives, acetophenetidin, acetanilid, bromides, thyroid, calomel, mercuric chloride, acetic acid, carbolic acid, etc. There were thirty-one criminal actions against the manufacturers or shippers of dangerous drugs. Twenty-three seizures of deceptively packaged drugs have been made during this time, and 215 actions were taken against various other drug products.

Action against devices and cosmetics.—Sixty-four seizures of dangerous devices, such as nipple shields containing lead, devices for forcing vapors under pressure into the nasal cavities, and mechanical prophylactics, have been made. There have been thirty-four seizures of and two criminal actions against manufacturers or shippers of therapeutic devices bearing misleading ther-

apeutic claims. These include health ray lamps, inhalers, vibrators, vaporizers, heat and light applicators, chemical heat packs, spine relaxers, and axine plates. One hundred forty-two actions have been taken against defective mechanical prophylactics. Of the 169 actions against cosmetics, 136 were against dangerous eyebrow and eyelash dyes, hair dyes, lotions, bleaches, and lipsticks. Thirty-three seizures were made of deceptively packaged tooth paste and powder, shaving creams, face creams, powder, eye drops, deodorant creams, depilatory creams, and hair and scalp preparations.

Investigation of Rubber Prophylactics

Among the articles against which we have been proceeding are rubber prophylactics. The attention which we have given to these devices has brought out a number of startling revelations. In July, 1938, a court decision in another case established a precedent for classifying such articles as drugs. The Food and Drug Administration undertook a survey of articles in this class and found the market literally flooded with articles that were full of holes or made of improperly cured rubber. We found that in certain lots as many as 93 per cent of the samples examined were defective and, therefore, worthless. An average of approximately 75 per cent of those on the market were defective to some degree. Under the old Food and Drugs Act, we had no authority to consider the birth control phases of the question, but we were concerned with the use of mechanical prophylactics for venereal disease prevention since we know that the public places its chief reliance in these articles for protection against venereal disease. I have often wondered why rubber prophylactics were rated so low as reliable contraceptive devices by those who had studied the situation. I think that our investigations have uncovered one of the principal reasons why this was true. Think of it. An average of three out of every four prophylactics sold contained holes and, in some instances, ninety-three out of 100 were defective.

We found that there is never a depression in this industry. Factories run night and day, seven days a week, and sales are constantly on the increase. We found that over one million mechanical prophylactics are used daily in the United States, and the public pays more than $50,000,000 annually for them. After the survey had shown such serious conditions, the Food and Drug Administration began regulatory action and in a short time seized more than one and three-quarters million of such mechanical prophylactics, including rubbers and skins, but mostly rubbers, on the charge that they were misbranded because they were labeled or purported to be disease preventives when, in fact, they were ineffective for this purpose.

Our investigations show that the principal cause of defects in rubber prophylactics is the dust particles which fall on the liquid latex which is being dried on forms. When the rubbers are completely dried, these dust particles will dislodge, leaving a hole where each particle had been. Our seizure actions became so extensive that the manufacturers could no longer do business since most of their output was at once apprehended by the Federal Government. Therefore, after a short time, the principal manufacturers closed their plants to effect extensive physical changes in building, equipment, and manufacturing processes. In some instances, the manufacturers who had been driven by a bad competitive situation welcomed our action and gave us splendid voluntary cooperation. The principal solution of the problem was so thoroughly to filter the air applied to dry the liquid latex while on the forms, as to prevent all dust damage. We believe all manufacturers in the industry, except a few small hand-dipping operators, have installed machinery wherewith the drying air is filtered through water. The second solution is so thoroughly and carefully to test the articles as to eliminate defectives from commercial lots. All manufacturers have improved testing methods. The objective, to correct the deplorable conditions in the industry so as to insure effectiveness in disease prevention, has been largely achieved. Our present examinations show the better grades running nearly 100 per cent without holes. Defective prophylactics in material amounts are found now principally in "seconds," that is, rejects sorted out on testing. Such "seconds" are now sold

more generally for export to South American countries, but many lots find their way into domestic commerce. The Administration is lending every effort toward apprehension of all such shipments.

Clinical Thermometers

Since the law became fully effective, we have made a study of clinical thermometers, a device under the terms of the Act. We have found that many instruments on the market are defective in that they fail to give a reliable temperature reading under the conditions of use. A series of clinical tests likewise indicated that representations such as "one-minute thermometer" had no meaning insofar as the actual use of the instrument was concerned. The vast preponderance of instruments so marked failed to give consistent or reliable reading within the time specified and, in some instances, a so-called "one-minute thermometer" took five minutes to reach equilibrium and thus give a reliable reading. Our investigation likewise showed that neither the public nor members of the professions knew exactly how long the thermometers they were using had to be kept in place to provide satisfactory readings. For these reasons, among others, we have taken steps to correct this situation. It is our interpretation of the intent of the law that each instrument should bear an accurate representation of the length of time necessary to give a reliable reading, and that this time should be determined under ordinary conditions of use and not in a laboratory water bath. Recognizing a number of competitive evils, reputable manufacturers of clinical thermometers have given very encouraging cooperation in the steps we have taken to protect the public from deception and misdirection.

Help Needed

The protection of the public from injury and deception in the field of foods, drugs, devices, and cosmetics is at once a grave responsibility and a prodigious task. We cannot do it alone. We are vitally dependent upon experts in every field for facts, observations, and opinions. Congress has not provided us with facilities nor the personnel to make clinical tests of drugs, devices, or cosmetics, ourselves. We are dependent upon the reports of your experiences and your cooperation in applying science to our task. When you see injuries resulting from dangerous articles, we hope that you will report them in the literature or directly to us. We must have access to case records and when we take steps to protect the public against dangerous or adulterated or misbranded drugs, devices, or cosmetics, we expect that we can count on you for help, and we believe that it is your civic duty as a good citizen to place your special talent at the disposal of your government. The Food and Drug Administration has always, as a matter of fairness and good government, spared no effort to avoid imposing on physicians. We cannot pay you adequately for the time you give us, but we never ask you to appear at legal proceedings without defraying the cost of your basic expenses and furnishing the standard honorarium or witness fee that has been set for this purpose. This witness fee has been $25 a day, which is not much but is at least some recompense for your devotion to the public good.

The influence of the work which we are doing is not altogether limited to goods moving in interstate commerce, which is the constitutional sphere of our authority. A number of states have adopted their own food, drug, and cosmetic acts patterned after the federal law. There is reason to believe that many more will do likewise. We have found that in many instances the states, and even some municipalities, follow up the steps we have taken with parallel actions. It is, therefore, all the more important that the work we do is thorough, well-advised, and scientifically sound.

In closing, I want to say that the protection of the public from dangerous or deceptive devices is your task as well as ours, and between us we should be able to make the beneficent Federal Food, Drug, and Cosmetic Act an important influence for good in this country.

The 1940 Blue Book number of *The Journal*, containing digests of laws on income tax, poor relief, pensions, malpractice, sterilization, workmen's compensation, abortion, narcotics, etc., will be mailed to members of the State Medical Society on December 10, 1940.

Medical Opportunities in a Small Urban Community*

By WARNER S. BUMP, M. D.
Rhinelander

Dean Middleton and Fellow Students of Medicine:

SOME weeks ago I accepted the invitation to meet with you, considering it much of an honor. However, as time has passed since that invitation, the responsibility associated with its acceptance has loomed greater and greater. As I began to render certain of my thoughts into words, I felt much as I have, when trying to write a letter. It seemed that my experiences had been most commonplace and that there was little to say which could possibly be new or of real interest to the reader or listener. It is, therefore, with a feeling of inadequacy that I attempt to put before you some of my opinions concerning the practice of medicine with special reference, as Dr. Middleton has suggested, to opportunities in the small community.

An opportunity is defined as a time or place suitable for executing a purpose. The purpose which we are discussing, namely, the practice of medicine, is that of the prevention of disease or the recognition of disease in its earliest stages to the end that measures may be taken to cure it or at least favorably modify its course and relieve suffering. A livelihood from these efforts is necessary and altogether fitting and proper; but the amassing of any great fortune can never be even a small part of the great purpose of the practice of medicine. The conditions suitable for executing this purpose must be based primarily upon needs.

About 460 B. C. on the island of Cos was born Hippocrates on whom history has bestowed the title of "Father of Medicine." He earned this title because he stressed the study of patients and the symptoms they presented; because he founded the bedside method of study, which was neglected for centuries and then was revived by him with such signal success that we still speak of the Hippocratic facies, Hippocratic fingers, and Hippocratic succussion.

After Hippocrates, progress was slow, indeed, until the great rebirth of medicine during the time of our fathers. In this short period more was learned in medical science than in all the preceding years. The changes initiated by Pasteur, Koch, Lister, Roentgen and many others have made medical science a most complex one, so that now no one individual can have full knowledge of the whole of it. The laboratory in all its branches—bacteriological, serological, and chemical—and instruments of precision have come to play an important part in medical practice. Complex and difficult methods of treatment have been evolved. As a result a great group of specialists in restricted fields of research and practice, of necessity, has arisen. And such specialism remains necessary to the progress of medicine.

On the other hand this has not been without harmful effects. Unquestionably it has made some forgetful that, after all, research in *medical* science has intrinsic worth only in so far as it is applied to the prevention of disease, the early recognition of disease, and the alleviation and cure of disease. One must not forget that it is through the study of the patient at the bedside by the practitioner of medicine that the benefit of research may reach those who need it.

To some extent I have made photography a hobby. With the camera in one spot, with the lens directed toward one scene, quite different pictures may be obtained simply by changing the lens. By using a lens of so-called normal focal length we obtain a picture of the scene much as the eye sees it. By using a lens of long focal length only a small part of the first picture is visible. This part is seen enlarged and rich in detail, but its relationship to the general scene can hardly be made out, except by consulting the picture taken with the lens of normal focal length.

I have often thought of medical science in the same light. Detailed, precise, and inten-

* Paper read before a University of Wisconsin Medical School convocation, November 23, 1939.

sive study in relatively limited fields by various specialists is required for progress. But the very concentration of these efforts narrows the field of view of the specialist, just as lengthening the focal length of the lens decreases the field of a picture. And a specialist, actively engaged in the pursuit of his own task, often has great difficulty in understanding the human individual as a whole. In fact it may be impossible for him to do so.

Specialists in research and specialists in branches of practice are very necessary; but the foundation stones of medical practice have always been and always must be the men of broad vision who see the patient as a whole and whose knowledge encompasses that of all medicine, without being burdened by the details which necessarily must be mastered by specialists.

There is, therefore, a fundamental need for the correlation of the work of the specialist and for the collection and analysis of scattered data, in order that they may be applied with due sense of proportion to the actual benefit of the sick individual.

As Carrell says, "Such a synthesis cannot be obtained by a simple roundtable conference of the specialists. It requires the efforts of one man, not merely a group." We have heard often of the science and the art of medicine. The application of the knowledge of the science of medicine to the needs of the ill individual is indeed an art, and works of art are seldom, if ever, produced by committees.

I repeat then that there is a real need for men with broad minds, who, considering their formal medical education merely as the tools with which to start, continue as students all their lives; men who are critical of tradition and, as well, are critical of the new; subjecting each so-called advance, each new drug, each new method of treatment to careful scrutiny and to serious study before applying it generally to their patients. There is a great need for men who, remembering the Hippocratic teachings, realize that in spite of the laboratory, there is no substitute for a careful study of symptoms and history and a thoughtful general examination of the individual. I am thoroughly convinced that most of the mistakes in diagnosis, and therefore most of the mistakes in therapy are due, not to lack of knowledge, but to failure to listen to the story of the patient, failure to make a simple inclusive physical examination, and failure to think about the data thus acquired. There is a great need for men of broad minds and wide knowledge to whom people may come when first ill, assured of a careful inquiry into their symptoms, and a general evaluation of their physical condition with recommendations for special minute examinations of parts of their bodies when indicated, to the end that no early cancer, no tuberculous focus, or other progressive lesion be overlooked. In other words, there is a great need for the man or woman who in the cities is called an "internist" and in the small communities is called a general practitioner of medicine. This man is the first line of defense against the onslaught of disease and the first line is very often the most important.

A short time ago in an editorial on cancer control Dr. Harold Foss stated that neoplastic disease when first discovered is definitely more advanced in country communities than in large cities and that the same holds true for every ailment of a chronic nature, requiring expert investigation and accurate diagnosis—heart disease, tuberculosis, diabetes, etc. This condition, he says, is partly due to poor lay education and part of the blame is laid at the door of the physician of the small community. Too often, Dr. Foss says, ergot is prescribed without a pelvic examination for Mrs. Jones who has noticed vaginal bleeding after the menopause; or Mr. Jones is treated for piles because of rectal bleeding, without being given the benefit of a digital or proctoscopic examination.

Testimony, such as this, adds emphasis to the need, especially in the smaller communities, for general practitioners who are conscious of their responsibility and who are thoughtful and thorough in their inquiry into the causes of their patients' symptoms. From time to time an occasional physician has told me that he could not take time to inquire into his patient's history with much care, nor could he take much time for a

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thorough physical examination, because patients did not desire to pay for such time. The seeming willingness to pay for prescriptions, drugs, parenteral injections, or physical procedures, has led such physicians into the path of least resistance and there is little to demarcate them from the vendors of so-called patent medicines and the members of irregular cults. I have seen more than a few patients who have had extensive treatment with such preparations as progestin, theelin, antuitrin–S, and other products when no pelvic examination had been made and no accurate diagnosis made.

A patient usually consults a doctor because he is conscious that there is something wrong with him. The important thing to the patient is this question, "What bearing has the cause of my symptoms upon my future?" When the physician accepts a patient, he should accept the serious responsibility of answering this question to the best of his ability. From talks with many laymen, I feel very sure that people greatly desire physicians who will listen patiently to their complaints and then thoughtfully evaluate the symptoms and physical findings in the light of past study and experience in an honest attempt to answer this all important question.

It is the necessity of answering this question which governs all clinical investigation and it is this necessity which gives to clinical medicine an aim peculiar to itself and distinct from investigation in any other field. A physician who says he has not time to make a clinical examination, has not time to practice medicine. The prescribing of remedies which do not remedy any more than the various patent medicines, or the application of physical methods of treatment when not indicated, or the creation of an air of mystery is not the practice of medicine. And I believe that the patient is definitely demanding sounder thought and sounder advice. He desires first of all to know what his condition actually is, and then whether or not treatment is really necessary, and if necessary what the probable result of treatment will be. If these questions cannot be answered without special examinations or if special types of treatment are necessary, he demands that his physician advise him honestly how and where to obtain them. The physician who meets these demands is a real physician and a wise physician. There is a need for him every place; but especially in the small community.

Some time ago it was my very good fortune to have the opportunity to talk informally with Dr. Ludvig Hektoen. We were discussing the early days of medicine in Chicago, that period shortly after the introduction of bacteriology, pathology, and antiseptic surgery. Of course, no such discussion could be indulged in without prominent mention of Christian Fenger, the first man to bring a sound knowledge of pathology to Chicago and who became one of the great surgeons of the Middlewest. I asked Dr. Hektoen to give me an idea as to the comparative attainments of Dr. Fenger and another world-famous Chicago surgeon of the same period. Dr. Hektoen's answer was in this fashion: It was customary in those days, he said, for surgeons to lecture in large amphitheaters with the patient in front of them. Then the operation was performed in the amphitheater and at the next clinic, the patient, if well enough, was brought back for discussion of the postoperative course. On such an occasion the second great surgeon, upon finding considerable purulent material on the dressings, was known to remark, "Ah! just a little physiological wound secretion; just a little physiological wound secretion."

However, when Dr. Fenger, whose only fault was an uncontrollable profanity, was confronted with the same situation, his audible reaction was: "Pus! by God, it's pus." Fenger saw things uncolored by his own desires. He never tried to delude himself nor those about him. He was honest, absolutely honest, to himself, to his colleagues, and to his patients.

Francesco in his book, "The Power of the Charlatan," points out that mystery is essential to the imposter. He states, "Above everything else, the charlatan must avoid straightforward reasoning and simplicity of expression: too clear and direct a light would quickly destroy the spell he exerts, through eloquent ambiguity, over his vic-

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tims." The charlatan has nothing to offer but the mystery of his spell. The physician has at his command a vast reservoir of scientific achievement which only looms the greater when clearer light is thrown upon it. The physician, therefore, should never fear to explain his concepts to his patient with simple straightforward reasoning. If there is no rational treatment for a patient's condition and the disease is a self-limited one, let the physician refrain from prostituting himself by the prescribing of useless drugs. Let him honestly explain the situation to the patient and thereby set himself and his profession apart from the charlatan.

Leonardo in his precepts to the painter said, "Do you therefore take care lest the greed for gain prove a stronger incentive than renown in art, for to gain this renown is a far greater thing than is the renown of riches." Of all people in the world, the physician should be honest. Especially at this very time, when pressure-groups seek to change our system of medical practice, can the physician himself, the profession in general, as well as the public, benefit from an honest, unselfish ministration to the sick.

Today there are many who desire the public to feel that medical care costs too much; that only well-to-do people may have good care; and that those in very modest circumstances are doomed to only cursory examinations and haphazard treatment, or no care at all. These groups would have people believe that specialism, the laboratory, and mechanical methods of diagnosis and treatment have made medical services much like impersonal packaged goods which can be produced in mass and delivered cheaply over the counter with standardized precision by a regimented profession.

That this vision is a mirage, based upon false conceptions of medical practice, is very clear, indeed, to thinking physicians. And it is quite fitting that they should spend some time in legislative halls to prevent great harm by misguided zealots. But it is much more important that physicians inform the people, their patients, by their daily acts, by their careful thought on each individual problem, and by their scientific and moral honesty that the practice of medicine is indeed a science and an art to be applied most personally, rather than according to some rigid mold prescribed and standardized by a committee or bureau. It is the general practitioner whose advice is first sought by the person who feels something wrong. It is the competent and honest service of a great group of general practitioners working with personal responsibility to each patient, that is the best guarantee of the early recognition and prevention of disease. And the public's realization of this truth is the bulwark against social change harmful to the integrity of the profession and the health of the people.

Fellow students of medicine, I believe the greatest need in medicine today is for the kind of a general practitioner whose portrait I have roughly sketched for you. I believe that the smaller communities have the greatest need of him. And, I repeat, opportunities are based upon needs.

Do not think I do not realize that to become such a physician is a difficult task and that to continue as one is also difficult. To become a great physician undoubtedly requires more imagination, more judgment, more intelligence, and, I believe, more industry than to become a great specialist in a basic science or in a limited field of practice. "Strong and broad minds are rarer than precise and narrow ones."

(To be continued in a subsequent issue of The Journal.)

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Endocrine Therapy in General Practice. By E. L. Sevringhaus, M.D., F.A.C.P., professor of medicine, University of Wisconsin, Madison. Ed. 3, enlarged and completely revised. Cloth. Price, $2.75 postpaid. Pp. 238, with 49 illustrations. Chicago: Year Book Publishers, 1940.

The same unqualified recommendation given to the first edition of this important book can be repeated for this second edition, which has been expanded and brought up to date without loss of its brief, concise manner of presentation of the material. Endocrinology is a difficult and almost mysterious field to many practitioners, but with the aid of an authoritative guide of this sort, it should be possible to treat endocrinopathies with a considerable degree of assurance and intelligence. The author's qualifications to write on this subject need little comment since he has had wide experience in both experimental and clinical endocrinology. The authority of his position adds immeasurably to the value of this volume to the practicing physician. E. S. G.

Vitamin Therapy in General Practice. By Edgar S. Gordon, M.D., M.A., associate in medicine and instructor in physiological chemistry, University of Wisconsin, and Elmer L. Sevringhaus, M.D., F.A.C.P., professor of medicine, University of Wisconsin. Cloth. Price, $2.75. Pp. 258, illustrated. Chicago: The Year Book Publishers, 1940.

This book offers much more useful information than the title would indicate. Not only are the vitamins discussed, clearly and adequately, but approximately two-fifths of the book is relegated to discussion of other food substances; minerals, proteins, fuel foods, carbohydrates and fats. In separate chapters, weight control, dental problems in nutrition, and the economics of nutrition—an especially important and well-considered phase—are discussed. In addition, there are tables giving sources of food elements and vitamin values of various foods which are completely up to date and excellent for reference by the clinician.

The major portion of the book is devoted to discussion of vitamins A, B, C, D, E, and K. The chemistry of each and of the various components is briefly and clearly analyzed, thus furnishing a scientific background for the clinical discussions that follow. The conditions which attend and cause the various deficiencies, and the indications for administration of the particular vitamin in each instance are discussed. Of particular value to the clinician are the specific recommendations for dosage wherever possible. The authors decry wastage but emphasize the need for adequacy in therapy.

They have discussed with conservatism the multiple and frequently unwarranted claims for various vitamins in clinical therapy.

The information in this volume is adequate, accurate, practical and includes the most recent advances in vitamin and dietary therapy. It includes material as recent as of June 1940. There are several satisfactory illustrations. The printing and binding are good and the book is well written and pleasing in appearance. The authors are to be congratulated on this timely work which can be highly recommended to clinicians as a library addition and an excellent source of ready reference. O. O. M.

Heart Failure. By Arthur M. Fishberg, M. D., associate in medicine, Mt. Sinai Hospital, New York City. Ed. 2, revised and enlarged. Cloth. Price, $8.50. Pp. 829, illustrated with 25 engravings. Philadelphia: Lea & Febiger, 1940.

This second edition, like the first, has its foundation on sound physiologic principles. The author follows closely the arrangement of the first edition, but incorporates the newer basic advances in the circulatory field which are fundamental, clarifying especially the most recent conceptions of the dynamics of pathologic physiology.

It is a well-written, sound work, worth digesting. H. H. S.

Management of the Cardiac Patient. By William G. Leaman, Jr., M. D., F. A. C. P., assistant professor of medicine in charge of the department of cardiology, Woman's Medical College of Pennsylvania, Philadelphia. Consulting cardiologist, St. Luke's and Children's Hospital, Philadelphia, etc. Cloth. Price, $6.50. Pp. 705, illustrated. Philadelphia: J. B. Lippincott Company, 1940.

This up-to-the-minute book faithfully carries out the author's desire to lay before the general practitioner a composite picture of the management of heart disease. He effectively uses the case history method of presentation, giving examples of almost every cardiovascular problem which may confront the practitioner. Illustrations of equipment and the technic for their utilization in the various diagnostic and therapeutic procedures are grouped with reproductions of the roentgenogram, orthodiagram, and electrocardiogram, and autopsy specimens, whenever possible, to bring together the clinical and laboratory data into a compact whole.

Treatment is stressed, the most recent methods emphasized, and, as a whole, fairly and impartially evaluated. In no other book does the practitioner get a more clear cut and easily understandable view of

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*Medical Record, August 21, 1940

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such therapeutic adjuncts as orthodiascopy and electrocardiography; the separate section on the latter deserving special mention. The importance of diet is very well worked in and the section on social service in the treatment of heart disease answers a crying need for clarifying and emphasizing that important phase of therapy. The allergic approach is interesting.

There is a goodly amount of contribution by the author's colleagues, but it is his own frankly refreshing and almost whimsical personal element that adds greatly to this easily read, worthwhile book. H. H. S.

Clinical Biochemistry. By Abraham Cantarow, M.D., associate professor of medicine, Jefferson Medical College; biochemist, Jefferson Hospital, Philadelphia, and Max Trumper, Ph.D., clinical chemist and toxicologist, formerly in charge of the laboratories of biochemistry, Jefferson Medical College and Hospital, Philadelphia. With a foreword by Hobart A. Reimann, M.D., professor of medicine, Jefferson Medical College, Philadelphia. Ed. 2, revised. Six hundred and sixty-six pages. Price, cloth, $6. Philadelphia: W. B. Saunders Company, 1939.

This book treats in a very comprehensive manner, the biochemical changes related to disease processes. This is an important aspect of internal medicine which unfortunately is poorly understood by most practitioners, and consequently the volume serves a very useful purpose in clarifying many details of pathology and therapy which are dependent upon chemical changes. Separate chapters are provided for the discussion of each nutritional factor, but the vitamins probably receive, relatively, less attention than they deserve. Very complete are the chapters on renal and liver function, with particular emphasis placed upon the details of various diagnostic procedures.

This volume has very apparently been written with the diagnostic value of the clinical laboratory clearly in mind. It is particularly valuable from the practical standpoint in steering the clinician who wishes to make the most out of his available laboratory facilities. From the standpoint of exposition of the biochemical theory underlying disease processes, this reviewer feels that this book is probably less useful than some others which have recently become available. Nevertheless, it is a valuable reference book, and should be used on this basis. E. S. G.

Physical Diagnosis. By William Nance Anderson, B.Sc., M.D., associate clinical professor of medicine in the University of Southern California School of Medicine, Los Angeles, California. Cloth. Price, $4.75. Pp. 424, illustrated with 92 engravings. Philadelphia: Lea & Fegiber, 1940.

This newest contribution to an already competently covered field of text books in physical diagnosis is, in general, authoritative and reliable, but offers nothing that adds any significantly new contributions to the subject. The best portion of the book, in the reviewer's opinion, is the opening chapter on the evolution of physical diagnosis. This might be read with profit by every student beginning his medical education. There are a number of minor details in which the reviewer cannot agree with the author, but these are not of enough importance to detract significantly from the value of the book as a whole. If this text were not entering a field in which a number of very satisfactory books have already been published, it could be more enthusiastically greeted. M. L. C.

Health Under the "El". The Story of the Bellevue–Yorkville Health Demonstration in Mid-town New York. By C. E. A. Winslow, professor of public health, Yale University School of Medicine and Savel Zimand, formerly administrative director, Bellevue–Yorkville Health Demonstration. With a foreword by Fiorello H. La Guardia, Mayor of New York City. Cloth. Price, $2.25. Pp. 203. New York: Harper and Brothers, 1937 (for the Milbank Memorial Fund).

Facts and figures can be made fascinating, as the authors of *Health under the "El"* prove. This third narrative report of a Milbank Memorial Fund Health Demonstration seems more crowded with details than the other two books** but these details only serve to bring more graphically to the reader's mind something of the tragedy and magic which is New York.

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attaining this goal were not to be limited to the application of already known principles of public health education. The experimental nature of the demonstration's program was to be exemplified in this department as in others. From the beginning it was a real educational project, not simply a far-flung publicity program. Its purpose was the spreading of actual health knowledge, and the development of an active desire to apply that knowledge through community cooperation."

For anyone not acquainted with the complicated set-up of health and social work in a large metropolis this book might prove to be slightly confusing. But to anyone who has visited tenement families, struggled with the intricacies of coordinating work in a community, and then has seen a gradual but noticeable change in its attitude—to him it will be reliving his own experiences. And to anyone who hopes to do these things this book will give help, encouragement, and inspiration. J. A. D.

A Textbook of Medicine (by American Authors). Edited by Russell L. Cecil, A.B., M.D., Sc. D., professor of clinical medicine, Cornell University Medical College; associated attending physician, New York and Bellevue Hospitals, New York City, and Foster Kennedy, M.D., F.R.S.E., professor of clinical neurology, Cornell University Medical College; attending physician, New York Hospital; visiting physician in charge, neurological service, Bellevue Hospital; consulting physician, New York Neurological Institute. Ed. 5, revised and entirely reset. Cloth. Price, $9.50. Pp. 1744 with 173 illustrations. Philadelphia: W. B. Saunders Company, 1940.

This excellent textbook is up to the standard of previous editions. It has been kept up to date in such departments as chemotherapy. It is of particular use in orientation for students and as a quick reference book for doctors. The authors are among the leaders in this country. It includes perhaps too many diseases, with a resultant reduction in discussion of some of the more important illnesses that can be found in some of the systems of medicine. C. F. M.

Physical Diagnosis. By Ralph H. Major, M. D., professor of medicine in the University of Kansas. Ed. 2, revised. Cloth. Price, $5. Pp. 464, with 437 illustrations. Philadelphia: W. B. Saunders Company, 1940.

This revised second edition is an improvement over an excellent first edition. The sections on the abdomen, the nervous system and the extremities have been enlarged and extended. Although much new material has been added, sufficient condensation has been achieved that the size of the book remains essentially unchanged. A particular feature of improvement is the addition of many new and excellent illustrations. The reviewer's chief criticism of the first edition was the inadequacy of the chapter on history taking. This has been revised to the extent of adding a more comprehensive discussion of a neurological history, but still fails to measure up to the high standards of the remainder of the text. M. L. C.

COMING EXAMINATIONS

Board of Examiners in the Basic Sciences: Milwaukee, Dec. 7. Sec., Prof. Robert N. Bauer, 3414 W. Wisconsin Ave., Milwaukee.

Board of Medical Examiners: Madison, Jan. 14–17. (Basic science certificate required.) Sec., Dr. H. W. Shutter, 425 E. Wisconsin Ave., Milwaukee.

American Board of Anesthesiology: Written. Various centers, Feb. 20. Final date for filing application is December 21. Oral. Part II. Cleveland, May 31–June 1. Final date for filing application is April 1. Sec., Dr. Paul M. Wood, 745 Fifth Ave., New York.

American Board of Dermatology and Syphilology: Oral. Chicago, Dec. 6–7. Applications for Group A are closed. Sec., Dr. C. Guy Lane, 416 Marlboro St., Boston.

American Board of Internal Medicine: Written. Parts 1-A and 1-B, Feb. 17. Final date for filing application is Jan. 1. Sec., Dr. William S. Middleton, 1300 University Ave., Madison, Wis.

American Board of Obstetrics and Gynecology: Part II, Groups A and B, Cleveland, May 28–June 2. Final date for filing application is March 15. Sec., Dr. Paul Titus, 1015 Highland Bldg., Pittsburgh.

American Board of Ophthalmology: Oral. Cleveland, May or June. Written. Various centers, March 8. The only written examination during 1941. Applications must be on file not later than Dec. 1. Sec., Dr. John Green, 6830 Waterman Ave., St. Louis.

American Board of Orthopaedic Surgery: Oral and written. New Orleans, January 1941. Final date for filing application is November 15. Sec., Dr. Fremont A. Chandler, 6 N. Michigan Ave., Chicago.

American Board of Pathology: Oral and written. Cleveland, June 1–2. Final date for filing application is May 1. Sec., Dr. F. W. Hartman, Henry Ford Hospital, Detroit.

American Board of Pediatrics: New York, March 30–31, following the Region I meeting of the American Academy of Pediatrics. Chicago, May 18, following the Region III meeting of the American Academy of Pediatrics. Sec., Dr. C. A. Aldrich, 723 Elm St., Winnetka, Ill.

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Working with institutionalized patients, Reifenstein and Davidoff did not find 'Benzedrine Sulfate' therapy satisfactory in chronic alcoholism.

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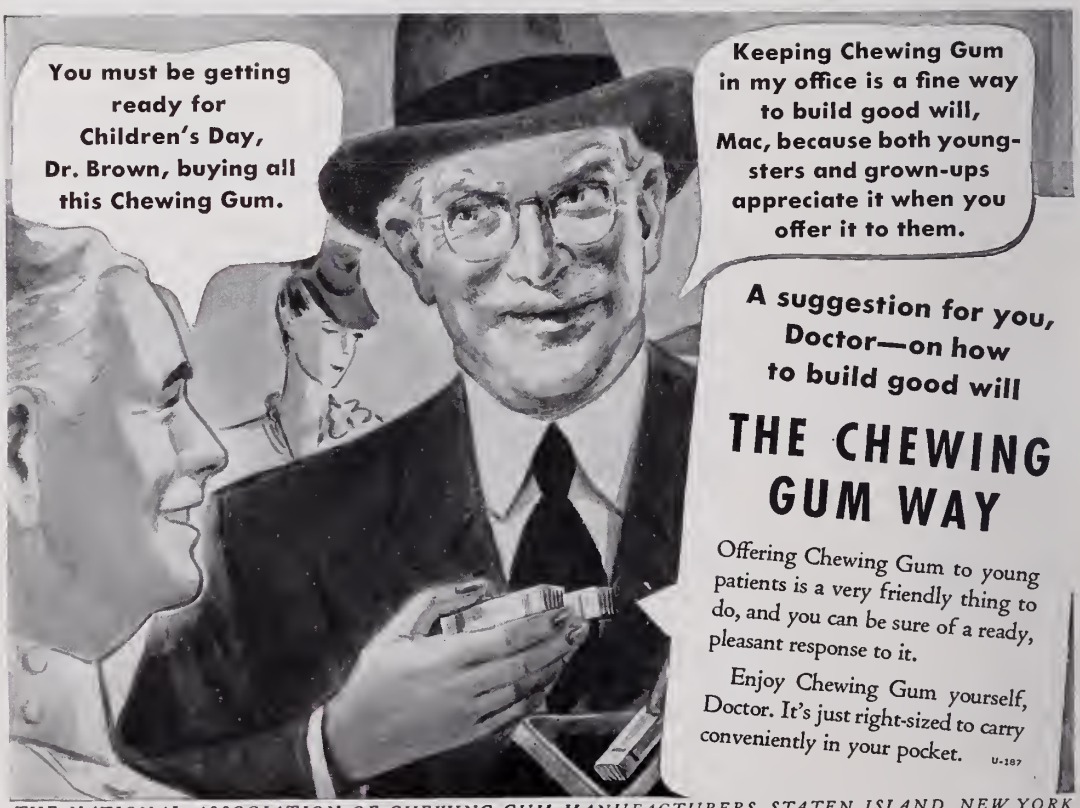

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STUDIES IN THE AVITAMINOSES

This page is the final of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the December 7 issue of The Journal of the American Medical Association.

The Exacerbation of LATENT PELLAGRA by Acute Infections

Vitamin requirements are increased by many factors, especially by acute infectious disease. Field, commenting on this phenomenon, states that the onset of pellagra may coincide with pregnancy, organic gastrointestinal disease, severe and prolonged illnesses, and dietary restriction for therapeutic purposes. The patient whose tongue is shown developed this manifestation of pellagra during the course of lobar pneumonia. After nicotinic acid therapy was started she coughed up a cast of the esophagus which consisted of a grey membrane similar to that covering the tongue. The pellagrous symptoms responded promptly to treatment.

Illustration courtesy of Virgil P. W. Sydenstricker, M.D., University of Georgia Medical School, Augusta, Ga.

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The Coexistence of Vitamin Deficiency States

Many authors have recently presented evidence that vitamin deficiency states often are multiple. Strauss has called attention to the fact that deficiency disease in man, unlike that experimentally produced in animals, is rarely limited to a single factor. The patient whose hands are shown had partaken of a markedly deficient diet for several months. As a result, scurvy and pellagra developed concurrently. The ecchymoses of the former and the dermatitis of the latter are clearly visible. Specific therapy together with dietary adjustment led to prompt remission of these signs.

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CANNED FOODS IN THE MODERN PATTERN OF NUTRITION

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During recent years, several excellent texts have become available which present reliable guidance in diet planning (1, 2, 3). One important factor governing conformance with any diet pattern, of course, is the economic status of the individual, family, or group. A recent text presents a workable system in which rather full consideration has been given to this factor (1).

Under this pattern, the common foods have been classed according to their nutritive contributions into some 12 groups. These groups include milk; potatoes and sweet potatoes; mature dry legumes and nuts; tomatoes and citrus fruits; leafy green and yellow vegetables; other vegetables and fruits; eggs; lean meat, poultry, and fish; flour and cereals; butter; other fats; and sugar. There will, of course, be quantitative differences in the nutritive values of individual foods within a single group. However, there is sufficient similarity so that the foods within a group can be used interchangeably as conditioned by factors such as availability, relative costs, and personal, racial, or religious preferences. In order to minimize variation of nutritive values obtained from each food group, it has been suggested that as wide a variety of foods within a group, as practical, be consumed.

In connection with this diet plan, desirable yearly food allotments for persons of various sex, age, or conditions of life are also listed in terms of these twelve food groups. Thus, from information regarding the sex, age, and activities of the members of a family or group, one can compute the yearly amounts of the various foods which should be provided. From the sum of these yearly totals, the food allowances per week or month for the family or group can be estimated. The latitude in the choice of foods, within the twelve specified food groups, makes the diet pattern more adaptable to situations where the economic factor must be considered.

Estimation of food requirements in this manner provides a practical method of diet planning designed to supply the nutritive requirements of an individual, a family, a group, or even a nation. However, the ultimate achievement of an improved nutritional status is dependent upon a readily available supply (at all times) of the various common foods at reasonable cost. It is apparent from the listing of the twelve food groups that many materials of a perishable nature—which are not conducive to year-round production near the centers of large populations—are indispensable in supplying the dietary requirements of our people. Thus, the transportation and storage of foods, in such a manner as to retain nutritive values, are important problems to be considered.

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REFERENCES

1. 1939. Food and Life; Yearbook of Agriculture, U. S. Dept. of Agriculture, U. S. Govt. Printing Office, Washington, D. C.
2. 1939. Accepted Foods and Their Nutritional Significance, Council on Foods of the American Medical Association, Chicago.
3. 1940. J. A. M. A. 114, 548.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-sixth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

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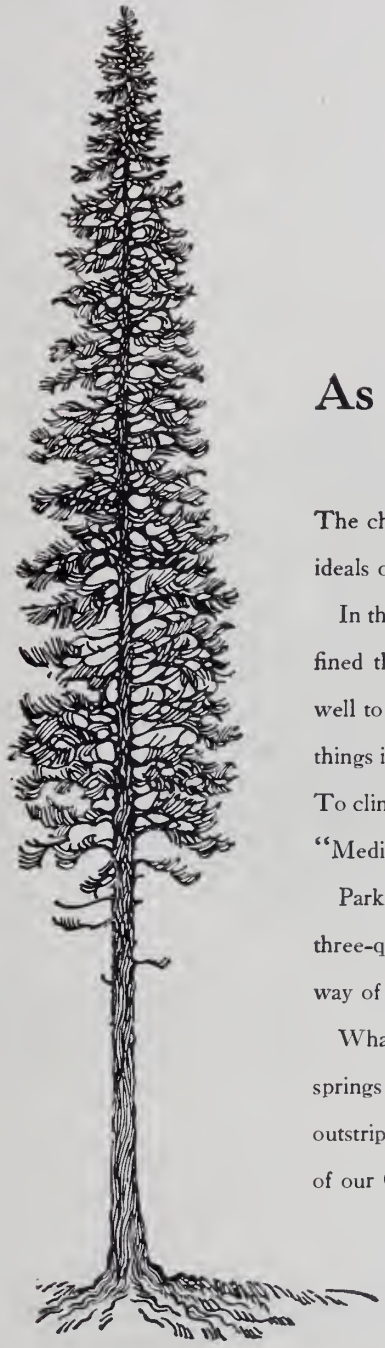

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Income Tax Provisions Affecting the Medical Profession

I. FEDERAL

GENERAL INSTRUCTIONS

Returns for all taxpayers reporting on a calendar year basis, must be made to the collector of internal revenue of the district in which the individual affected resides, before March 15, 1941, at which time the tax is due and payable. In the event the taxpayer desires to pay his tax on the installment basis, the first installment of one quarter of the tax is due on March 15, 1941, and a quarterly installment every three months thereafter; namely, June 15, September 15 and December 15. An extension of the time for filing a return can be had for reasonable cause. Application for extension should be filed with the collector of internal revenue in the district in which the applicant resides. Such application should be made before March 15 under oath on Form 1134, copies of which may be obtained from the collector of internal revenue.

Responsibility for making these returns is vested in the individual. As will be noted from reading the paragraphs following, liability to make a return depends not on whether one has a tax to pay, but on the amount of his reportable income.

All persons deriving incomes from a business, investments or profession are required to file their return upon the large form, 1040. This form is also used by persons reporting an income of $5,000 or over, regardless of the nature of its source. The small form, or 1040A, is for persons who secure their incomes from wages, salaries, interest, dividends, or annuities, the gross amount of which is less than $5,000.

The large form, or 1040, will be mailed to all Wisconsin physicians by the collector of internal revenue. If such blank is not received, apply to the collector of internal revenue of the district in which you reside.

Every married person, living with husband or wife, having a *gross* income of $2,000 or over, and every husband and wife, who live together and have an aggregate *gross* income of $2,000 or over, must file separate returns, or a joint return, regardless of the amounts of their joint or individual *net* incomes. Every single person and every married person not living with husband or wife, having a *gross* income of $800 or over must also file a return irrespective of his individual *net* income.

The *normal* tax rate for the calendar year 1940 is 4 per cent on the *net* income in excess of exemptions, credits for dependents, earned income credit, and credit on the obligations of the United States and its instrumentalities. *Surtaxes*, which are graduated, are applicable only to those individuals whose *net* incomes (after deduction of personal exemptions and the credit for dependents, but no other credits) exceed $4,000. Surtax rates begin at 4 per cent and are graduated rather sharply upward as income increases.

There has also been enacted a five-year *defense* tax, the amount of which is 10 per cent of the sum of the normal tax plus any surtax, except for very large incomes, in which latter cases the defense tax is computed somewhat differently.

If the marital status of a taxpayer changes during the taxable year, the personal exemption shall be an amount which bears the same ratio to $800 as the number of months during which the taxpayer was single bears to twelve months, plus an amount which bears the same ratio to $2,000 as the number of months which the taxpayer was married and living with husband or wife or was the head of a family bears to twelve months. For this purpose a fractional part of a month shall be disregarded unless it amounts to more than half a month, in which case it shall be considered as a full month. Changes in the credit for dependents allowed a taxpayer are apportioned in like manner.

EARNED INCOME CREDIT

A credit against net income, for the purpose of the normal tax only, is allowed by the 1940 law, calculated at 10 per cent of the earned net income. All net income up to $3,000 is considered to be earned net income regardless of its source, and the maximum earned net income that may be considered is $14,000. Thus the maximum earned income credit allowable against net income for the purposes of the normal tax is 10 per cent of $14,000 or $1,400.

Earned net income is defined as the excess of the amount of earned income over the sum of deductions and expenses properly chargeable against or allocable to the earned income. Under the statute earned income means "wages, salaries, professional fees, and other amounts received as compensation for personal services actually rendered." In a professional occupation the taxpayer may include as earned income all professional fees even though assistants perform the services, provided the clients are those of the taxpayer.

DETERMINATION OF INCOME

The term *gross* income as applied to a physician includes the total compensation received by him during the taxable year for professional services, including receipts from the sale of spectacles, in whatever forms such compensation may be paid, including compensation paid by a state, plus the amount received in interest, rent, dividends, securities, or from the transaction of any business conducted by such physician, or the sale of any capital assets.

Acknowledgment is made of the courtesy of both federal and state tax officials in reading this material and in making suggestions, all of which have been incorporated. Wherever references are made to form numbers or to general requirements below, it is on the basis that the tax officials anticipate that such forms or such requirements will continue unchanged.

The term *net* income as applied to a physician means the *gross* income computed under the above definition less allowable deductions for professional expenses. What constitutes allowable deductions will be considered in detail in the subsequent paragraphs.

The term *deduction* as applied to a physician means any amount allowable as a professional expense. Various classes of deductions are treated in detail below.

The terms *personal exemption* and *credit for dependents* have reference to the amounts allowed because of one's marital status or family obligations. These matters are treated in full detail in the instruction sheet attached to the return.

ITEMS NOT REPORTABLE AS INCOME

The following items are not required to be reported because exempt from taxation: gifts, bequests, devises and inheritances; dividends on stock of federal reserve banks, land banks, intermediate credit banks and national farm loan associations; dividends from corporate earnings accumulated prior to March 1, 1913; amounts received through health, accident or workmen's compensation insurance, and damages received by the taxpayer for illness or injuries suffered by him; life insurance proceeds paid by reason of death of the insured (where a policy matures during life the amount of the proceeds, in excess of the net premiums paid, is taxable income); corporate stock dividends of the same kind as previously held by the taxpayer in the issuing company; payments to war veterans under the Adjusted Compensation Payment Act of 1936; earned income received from sources without the United States by a citizen who is a bona fide nonresident more than six months of the taxable year except amounts paid by the United States or any agency thereof; pensions and compensation received by veterans from the United States, and pensions received from the United States by the family of a veteran for services rendered by the veteran to the United States in war-time.

Interest on the following obligations is wholly exempt, but while excluded from taxation must nevertheless be reported on the proper schedules on the 1940 returns: Obligations of a state or political subdivision thereof, Treasury bills and certificates of indebtedness, Treasury notes, deposits in Postal Savings banks, and obligations of the United States issued on or before September 1, 1917, obligations of United States possessions, obligations issued under the Federal Farm Loan Act.

Interest on obligations of the H.O.L.C., Federal Farm Mortgage Corporation, and United States Housing Authority and dividends from federal savings and loan associations are exempt from normal tax, but are subject to surtax.

Interest from Treasury bonds, including United States Savings bonds, is exempt from normal tax, but is subject to surtax except for exemption to the extent of the interest received on the first $5,000 of principal of such bonds. Example—Taxpayer holds $10,000 in principal of Treasury bonds, equally divided between issues bearing interest at 3 per cent and 4 per cent. He may claim exemption from surtax as to the interest received on the $5,000 of 4 per cent Treasury bonds.

CAPITAL GAINS AND LOSSES

The provisions of the 1938 and 1939 Acts relating to taxation of gains and deduction of losses from sales or exchanges of capital assets differ from those in any prior law. Capital gains and losses of individuals are divided into two classes:

(1) *Short-term* capital gains and losses by which are meant those resulting from sale or exchange of capital assets held for not more than eighteen months;

(2) *Long-term* capital gains and losses by which are meant those from sale or exchange of capital assets held for more than eighteen months.

The following percentages of gain or loss recognized are to be taken into account in computing net income:

Short-term: 100 per cent if the asset has been held for not more than 18 months;

Long-term: 66⅔ per cent if held for more than 18 months and not more than 24 months;

50 per cent if held for more than 24 months.

The law also provides for alternative methods for computation of the tax in the case of net long-term capital gains or losses, but these are not applicable until the net income of the individual exceeds $40,000.

These new provisions are as yet untested either before the Federal Treasury Department or in the courts, and are of a highly involved character. It is recommended that any physician who made sales or exchanges of capital assets during the past year consult with his attorney, or accountant, or write for assistance to the office of the Collector of Internal Revenue at Milwaukee, before completing his 1940 return.

The following general points may be noted, however:

1. The term "capital assets" as defined in the act excludes property used in a trade or business which is subject to allowance for depreciation, such as a building or equipment. Thus if improved real

estate has been sold during 1940, only the land may be included under Schedule "F" of form 1040, dealing with sales or exchanges of capital assets, the building itself to be shown separately under Schedule "G".

2. If any securities issued by any corporation, including stocks, rights, bonds, debentures and other evidences of corporate indebtedness are ascertained to be worthless and are charged off within the taxable year, the loss resulting therefrom shall be considered as a loss from the sale or exchange of capital assets *as of the close of the taxable year.*

3. Individuals not involved in the sale or exchange of any capital or other assets during 1940 need have no concern over these capital gains or losses provisions, but as professional men, will make their return on the same form, 1040.

SPECIAL RULE ON ACCRUED ACCOUNTS RECEIVABLE

Certain types of taxpayers are permitted by the federal act to report income on a *cash* as distinguished from an *accrual* or due basis. This is in recognition of the fact that much taxable income is not received by certain business and professional men until long after the tax period in which the right to receive such income accrued. This is notably true of accounts receivable, and also of notes receivable, rent and interest receivable.

Example: A physician charges his patients a total of $15,000 on his accounts receivable records in a given year, but collects only $3,000 of it in cash during that year. He also collects in cash during that same year the further sum of $9,000 in payment of services rendered by him to patients in prior tax years. His gross *cash* income for that year is thus $12,000, while his gross income on an *accrual* basis is $15,000.

Generally speaking, it is advantageous from a tax standpoint for a physician to report and pay only what is actually received in accounts, notes, interest and similar items, because his losses from these sources are so much higher than those of a commercial concern.

Reporting of income on a cash basis has another side, however. The federal decisions have held that where income has accrued, that is, become earned and payable prior to the death of the taxpayer, but was not collected until subsequent to his death, such collections were *not* income to his estate and constituted merely the collection of assets. Not having reported such accounts as income during his life, and his estate not being taxable for their collection after his death, such accounts receivable as were uncollected at the time of death thereby escaped any income taxation. This created a tax inequality in favor of the physician reporting on a cash basis as against one reporting on an accrual basis.

To prevent this kind of income from escaping income taxes altogether the federal act was amended in 1934 to provide that amounts accrued to the date of death of the taxpayer be included in computing net income for the taxable period in which the date of death fell, and to provide further for allowance to such deceased taxpayer of all deductions and credits accrued during the same taxable period ending with the date of death. The effect of the statute is to place a taxpayer who dies during a given year on an accrual basis, both as to receipts and disbursements during that portion of the tax year ending with his death, even though he had previously reported on a cash basis.

This subjects to income taxation for the first time all of the unpaid accounts due the physician which are reasonably collectible. This would include not only accounts receivable but notes, interest and rent due. The statute also permits as credits against such income all expenses and other professional obligations which accrued during the tax period ending with the date of death, even though part of such expenses had not in fact been paid. The fact that the accrual rule operates as to expenses as well as to unpaid accounts is both fair and advantageous to the physician and other taxpayers.

Example: A physician whose tax year ends on December 31 dies on July 1, 1940. During the six months of the 1940 tax year his gross *cash* income was $5,000. His books disclose that patients owe him $25,000, of which his estate can show $10,000 to be uncollectible, leaving net collectible accounts of $15,000. His estate must report as gross taxable income for the six-month period ending July 1, 1940, not only the $5,000 actually received in cash during that period but also the $15,000 of net accounts receivable (which have never previously been subjected to an income tax), or a total of $20,000. If the physician's professional expenses for the same six month period, whether paid or not, total $8,000, the net income subject to tax will be $12,000, exclusive of his credits for dependents, marital status, and earned income.

There is nothing startling or unconstitutional about this ruling which has been considered and upheld in several cases. It does nothing more than put *all* taxpayers, including physicians, on a uniform accrual basis. It would be well, however, for the practicing physician to observe the following bookkeeping precautions which may have the effect of reducing his tax liability in a proper and legal manner:

1. Do not enter on your books, as receivables, accounts due from patients, notes due from patients, interest from loans or other obligations due you, or rental to which you are entitled from leased property, where such items are of doubtful collectibility or known to be uncollectible. Your estate may have trouble in proving an account is bad and getting an allowance for it, thereby compelling payment of income tax on an account which neither you nor your heirs will ever collect.

2. Write off known bad accounts and notes at least annually, even though you are reporting on a cash basis. If you are reporting on an accrual basis, set up adequate reserves for bad and uncollectible accounts and charge against

the reserve all accounts known to be in this classification.

3. Keep in your files such information as your patients and other debtors volunteer, or which you obtain from other sources, which will provide a basis for showing such accounts to be uncollectible, or at least very doubtful.

4. If the due but uncollected items from patients and others is a substantial sum, you must make allowance for the additional income tax which will be involved following your death. This tax is computed as of the date of death but is actually prepared and handled by your administrator or executor. You should consult with your attorney or accountant in estimating the amount which would be due and have either cash or insurance available for this purpose if it should prove to be a substantial item.

This rule is limited to the federal income tax, does not affect the state income tax due, and does not involve the valuation of your assets or the computation of taxes due from your estate either to the federal or state governments.

PERSONAL EXEMPTIONS AND CREDIT FOR DEPENDENTS

In the case of a single person, a personal exemption of $800 is allowed as a deduction from net income subject to tax. In the case of the "head of a family," or of a married person living with husband or wife, a personal exemption of $2,000 is allowed. If a husband and wife living together make separate returns, the personal exemption may be taken by either of them or divided between them, but may not exceed $2,000 in the aggregate.

A credit of $400 is allowed for each person, other than husband or wife, dependent upon and receiving his *chief* support from the taxpayer, if such dependent person is under eighteen years of age, or is incapable of self-support for mental or physical reasons.

GREEN SHEET

For the past several years each person making a return has been required to file a duplicate income tax return known as the "green form." This duplicate was made available to proper municipal and state tax authorities on request, but was not available to the public, and the person failing to file such a duplicate return was subject to a $5 fine for his oversight. There is some uncertainty whether this requirement will be made in connection with 1940 income, and each person liable to make a return should be sure on this point at the time he begins the preparation of the original return.

INFORMATION AT SOURCE

Every person making payments of salaries, wages, interest, rents, commissions, or other fixed or determinable income of $800 or more during the calendar year 1940, to another person, is required to make a return on Form 1099 showing the amount of such payments and the name and address of each recipient, except that a return need not be made for payments of salaries or other compensation for personal services aggregating less than $2,000 made to a married individual. This form will be furnished by any collector of internal revenue upon request and must be forwarded to the Commissioner of Internal Revenue, Sorting Section, Washington, D. C., in time to be received not later than February 15, 1941.

DEDUCTIONS

Deductions which will be allowed on the tax return, some of which are peculiar to physicians, are listed below. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail how to arrive at the deductions and depreciation.

With reference to depreciation allowable, the rate of depreciation not only depends on the prospective life of the property when acquired but also on the particular conditions under which the property is used as reflected in the taxpayer's operating policy.

The rates given below are therefore suggestive and tentative rather than final in character.

A. Index to Deductions

Automobiles, 1.
  Depreciation.
  Insurance, 1, 11(b).
  Maintenance.
  Repairs.
  Salary of chauffeur.
Bad debts, 2.
Bandages, 4.
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  Automobiles—25 per cent annually on cost price, 1.
    Classification includes snowmobiles and other motive equipment.
  Instruments, 4.
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  Medical library, 3.
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  Office equipment, 5.
    10 per cent annually of cost price.
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  Both long and short-lived.
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Office rental, 6.
Professional dues, 7.
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    College of Physicians.
  Any other paid in interest of profession.
Professional subscriptions, 7.
Salaries, 10.
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  Clerk, 10.
  Laboratory assistant, 10, 11(c).
  Maid, 10.
  Nurse, 10.
  Stenographer, 10.
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B. Explanation of Deductions

1. **Automobiles.** The cost of operation and maintenance of an automobile used in making professional visits is deductible. These costs include gasoline, oil, tires, insurance, repairs, garage rental, chauffeur's wages and depreciation. If the same car is used for both professional and personal purposes, only such part of the maintenance and depreciation as arises out of the use for professional purposes is deductible. Sums spent for taxi, bus, or railroad fare, while on professional calls, are deductible.

Depreciation is based upon the estimated useful life of the car. If that period be four years, 25 per cent depreciation based on cost price may be taken annually for four years. What has been said with respect to automobiles applies to other motive equipment.

2. **Bad Debts.** If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debts because "if his books are kept according to this system, he is only reporting as gross income those accounts which have proved to be good and therefore bad accounts cannot be deducted because they have already been excluded."

If the books are kept upon an "accrual basis" (that is, on the basis of expenses actually incurred and payable even though not yet paid, or income earned although not yet collected), it is permissible to charge off all debts which have been definitely ascertained to be worthless, and have been charged off on the books or records, during the fiscal year covered by the report. *We urge all members who may be keeping accounts on the "accrual basis" to secure permission to change to a cash basis.* (In this connection see page 1012.)

3. **Library.** Most physicians maintain a professional library. Taken as a whole it is doubtful whether the useful life of such a library exceeds ten years. Accordingly annual depreciation equal to 10 per cent of the cost of such library may be deducted.

4. **Medical Supplies and Instruments.** Medicines used in the physician's office to treat patients, bandages, laboratory materials, and all other medical supplies required for the operation of a physician's office may be deducted as necessary expenses, as may equipment, the life of which is less than one year. The average useful life of surgical instruments and equipment generally is now estimated at ten years which means that 10 per cent of the cost may be taken as annual depreciation. X-ray equipment may be depreciated at 10 per cent of cost annually.

5. **Office Expense.** General office expense is deductible. Among the principal items are heat, light, office supplies, telephone, rentals, water, office equipment having a useful life of a year or less, and depreciation on office furnishings and fixtures. Ten per cent of original cost is a reasonable average depreciation rate for office equipment, furnishings and fixtures.

6. **Office Rent.** If a physician pays rent to another person for office space, he is permitted to deduct the amount from his gross income. This includes regular office space in a rented home provided office hours are maintained there. Where a physician maintains his offices in a rented home he may deduct as rental expenses only that proportion of the total rent paid which his office space bears to the entire house. If he owns his home and maintains an office in it, he cannot claim a deduction for office rent.

7. **Professional Dues and Subscriptions.** Dues paid to professional associations to which a physician belongs in the interest of his profession are deductible. Subscriptions to medical journals or scientific publications are likewise deductible.

8. **Taxes and Licenses.** Any taxes paid upon materials required in professional work are exempt. All licenses which the physician is required to take out

may be deducted. This includes the license to prescribe alcohol, narcotic license, automobile license, local occupational and reregistration taxes, state taxes on gasoline and motor oil for professional use of car, state income taxes paid, payments made under the Wisconsin unemployment compensation act and payments made by the physician as an employer under Titles VIII and IX of the Social Security Act. The social security tax deducted from the income of a salaried physician is not deductible by him, however, since it is considered an income tax.

9. **Traveling Expenses.** Traveling expenses necessary for professional visits to patients are deductible. Traveling expenses in bona fide attendance upon scientific meetings are deductible. The expenses of attending postgraduate medical courses are *not* deductible, however.

10. **Wages and Salaries.** Deductions are permitted for the salary of a nurse, laboratory assistant, stenographer or clerical worker employed in the office so long as the duties of such persons are in connection with the physician's professional work. Wages paid to maids taking care of the office and answering the telephones are also deductible, as are any sums paid employes for services rendered in connection with the taxpayer's practice, or the care and treatment of patients.

11. **Miscellaneous. (a) Legal Expenses.**—Legal expenses incurred in connection with the taxpayer's profession or business, including the prosecution of tax assessment or refund cases, are deductible, but legal fees paid for general personal legal services are not deductible. Expenses incurred in the defense of a suit for alleged malpractice are likewise deductible as business expense. Expenses incurred in the defense of a criminal action, however, are not deductible.

(b) Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Under professional equipment is to be included any automobile belonging to the physician and used for strictly professional purposes.

(c) Laboratory Expenses—The deductibility of the expenses of establishing and maintaining laboratories is determined by the same principles that determine the deductibility of other corresponding professional expenses. Laboratory rental and the expenses of laboratory equipment and supplies and of laboratory assistants are deductible when, under corresponding circumstances, they would be deductible if they were part of a physician's general office expense.

(d) Losses by Fire, Theft, etc.—Loss of and damage to a physician's equipment by fire, theft or other cause, *not compensated by insurance or otherwise recoverable*, may be computed as a business expense and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent it has not been made good by repair and the cost of repair claimed as a deduction. Deductions may likewise be taken for loss of or damage to *nonprofessional* property of a physician caused by fire, flood, theft or otherwise, *where not compensated for by insurance or otherwise.*

(e) Sale of Spectacles—Oculists who furnish spectacles, etc., may enter as income, money received from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should, in such cases, show charges for services separate and apart from charges for spectacles.

II. STATE

GENERAL INSTRUCTIONS

Returns of 1940 income must be made to the assessor of incomes of the district in which the taxpayer resides, on or before March 15, 1941. A written extension of the time in which to file may be granted for sickness or other sufficient cause by the assessor of the department of taxation for the district in which the taxpayer lives. Such extension must be on written request, may not exceed thirty days, is discretionary in the assessor, and will not be granted because of mere neglect of the taxpayer.

Every resident including minors from eighteen to twenty-one years of age, who received a net income of $800 or more if single, and $1,600 or more if married, must file a return whether notified to do so or not. The income of an emancipated minor under eighteen years should be included in the return of his father.

If the status of the taxpayer changes during the taxable year, insofar as it affects personal exemption for husband and wife, head of family, or dependents, such personal exemption shall be apportioned in accordance with the number of months before and after such change, disregarding a fractional part of a month unless it amounts to more than a half month, in which case it shall be considered as a month.

Every person having a legal residence in Wisconsin and every other person maintaining a permanent place of abode here, or spending in the aggregate more than seven months of the income year within the state, shall be deemed to be residing in Wisconsin for purposes of determining liability for income taxes and surtaxes. Liability for income taxation which follows the residence of persons moving into or out of the state in the tax year shall be determined by the ratio of time which the residence of such taxpayer in the state bears to the entire tax year. Deductions and personal exemptions are prorated on the basis of time of residence within and without the state, and the net income of such person

assignable to the Wisconsin residence shall be used in determining the income subject to tax.

The normal tax, which is graduated, varies from 1 per cent on the first $1,000 of net income to 7 per cent on net incomes in excess of $12,000. The teachers' retirement fund surtax is based on one sixth of normal taxes after deducting $37.50 from the net normal tax. The legislature continued the 60 per cent emergency surtax for the calendar or fiscal years 1939 and 1940. These are to be computed as before by the taxpayer on the same return with the normal tax, and are subject to the same personal exemptions as the normal tax. Full instructions will appear on the 1940 tax return.

All wages, salaries or fees derived from personal services performed for the United States or any agency or instrumentality thereof are now taxable, effective January 1, 1939. This changes the former rule exempting income from such sources.

The former provisions of the statutes relating to computation of capital gains and losses for surtax purposes have been repealed. Thus, full gains or full losses are now recognized irrespective of the time the asset was held, instead of being graduated, as formerly, on the basis of the time the asset was held.

In general, the definitions contained in the preceding federal income tax digest are applicable as well to state taxes.

INSTRUCTIONS ON THE FILING OF SEPARATE INCOME TAX RETURNS FOR HUSBAND AND WIFE

Section 71.09 (4) (c) requiring that the incomes of husbands and wives be combined for assessment purposes has been held unconstitutional by the United States Supreme Court. To give effect to this decision the Tax Commission has adopted the following regulations:

1. Wives must file a separate return on Form 1W if they have income of their own, but in case they have no income no return need be filed.

2. In the event that both husband and wife have income and file separate returns, the personal exemption of $17.50 for the head of a family may be divided between the two according to their own choice, that is to say, the husband may claim it all, or the wife may claim it all, or they may divide it between them as they see fit.

3. The income of children under eighteen years of age shall be included in the return of the husband, widow or head of a family and the personal exemption for such children or dependents shall be allowed to the husband or may be divided between him and his wife as they may elect, or shall be allowed to the widow having such children. The exemption allowed to the head of a family, other than a widow or widower, supporting children under the age of eighteen shall be limited to a deduction of $17.50 from the tax.

PERSONAL CREDITS AND EXEMPTIONS

The statutes themselves are so clear as to personal exemptions, credits for dependents, and the date determining the personal status of a taxpayer for income tax purposes that they are quoted here in full.

"71.05 **Exemptions.** (1) There shall be exempt from taxation under this chapter income as follows, to wit:

(a) Pensions received from the United States.

(b) All inheritances, devises, bequests and gifts received during the year.

(c) All insurance received by any person or persons in payment of a death claim by any insurance company, fraternal benefit society or other insurer, except insurance paid to a corporation or partnership upon the policies on the lives of its officers, partners or employes.

* * * *

(2) There shall be deducted from the tax after the same shall have been computed according to the rates in section 71.06, a personal exemption for natural persons as follows:

(a) For an individual, eight dollars.

(b) For husband and wife or head of a family, seventeen dollars and fifty cents. For the purposes of this chapter, the term 'head of a family' means a natural person who maintained a household and supported therein himself and one or more persons who were dependent upon him for support; but no additional exemption shall be allowed for those dependent upon the head of a family except in case of a widow or widower supporting children under the age of eighteen years.

(c) For each child under the age of eighteen years who is actually supported by and dependent upon the taxpayer for his support, an additional four dollars.

(d) For each additional person, except persons defined in subsection (2) (c) of section 71.05, who is actually supported by and entirely dependent upon the taxpayer for his support an additional four dollars, except in case of head of a family. In computing taxes and the amount of taxes payable by persons residing together as members of a family, the income of * * * each child under eighteen years of age shall be added to that of the husband or father, or if he be not living, to that of the head of the family and assessed to him except as hereinafter provided. The taxes levied shall be payable by such husband or head of the family, but if not paid by him may be enforced against any person whose income is included within the tax computation.

(e) If the status of the taxpayer, insofar as it affects the personal exemption for husband and wife, head of family and/or dependents, changes during the taxable year, the personal exemption shall be apportioned, under rules and regulations prescribed by the tax commission, in accord-

ance with the number of months before and after such change. For the purpose of such apportionment a fractional part of a month shall be disregarded unless it amounts to more than a half month, in which case it shall be considered as a month."

DEDUCTIONS

A. Statute

The statute is so explicit on what constitutes allowable deductions of major items of expense that it has seemed advisable to insert portions of it for the aid of physicians making state returns.

"71.04 Deductions from incomes of persons other than corporations. Persons other than corporations, in reporting incomes for purposes of taxation, shall be allowed the following deductions:

(1) Payments made within the year for wages or other compensation for services actually rendered in carrying on the profession, occupation or business from which the income is derived. But no deduction shall be made for any amount paid for services actually rendered in the carrying on of the profession, occupation or business from which the income is derived unless there be reported the name and address and amount paid each person to whom a sum of seven hundred dollars or more shall have been paid for services during the assessment year. No deduction shall be allowed under this section for any amounts expended for personal, living or family expenses.

(2) The ordinary and necessary expenses actually paid within the year in carrying on the profession, occupation or business from which the income is derived, including a reasonable allowance for depreciation by use, wear and tear of the property from which the income is derived * * *

(3) Losses actually sustained within the year and not compensated by insurance or otherwise, provided that no loss resulting from the operation of business conducted without the state, or the ownership of property located without the state, may be allowed as a deduction, and provided further that no loss may be allowed on the sale of property purchased and held for pleasure or recreation and which was not acquired or used for profit, but this proviso shall not be construed to exclude losses due to theft or to the destruction of the property by fire, flood or other casualty. No deduction shall be allowed under this subsection for any loss claimed to have been sustained in any sale or other disposition of shares of stock or securities where it appears that within thirty days before or after the date of such sale or other disposition the taxpayer has acquired (otherwise than by bequest or inheritance) or has entered into a contract or option to acquire substantially identical property and the property so acquired is held by the taxpayer for any period after such sale or other disposition.

(4) Dividends, except those provided in section 71.02 (2) (b) 2 and 3, received from any corporation conforming to all of the requirements of this subsection. Such corporation must have filed income tax returns as required by law and the income of such corporation must be subject to the income tax law of this state. The principal business of the corporation must be attributable to Wisconsin and for the purpose of this subsection any corporation shall be considered as having its principal business attributable to Wisconsin if 50 per cent or more of the entire net income or loss of such corporation after adjustment for tax purposes (for the year preceding the payment of such dividends) was used in computing the average taxable income provided by chapter 71 * * *

(5) Interest paid within the year on existing indebtedness; provided, the debtor reports the amount so paid, the form of the indebtedness, together with the name and address of the creditor. But no interest shall be allowed as a deduction if paid on an indebtedness created for the purchase, maintenance or improvement of property, or for the conduct of a business, unless the income from such property or business would be taxable under this chapter.

(6) Taxes other than inheritance and special improvement taxes upon the property or business from which the income hereby taxed is derived paid by such persons during the year, including therein taxes imposed by the state of Wisconsin or the United States government as income taxes; provided, that such portion of the deduction for federal income taxes as may be allowable shall be confined to cash payments made within the year covered by the income tax return; and provided further, that deductions for income taxes paid to the United States government shall be limited to taxes paid on net income which is taxable under this chapter; and provided further that income taxes imposed by the State of Wisconsin shall accrue for the purposes of this subsection only in the year in which such taxes are assessed.

(7) Contributions or gifts made within the year to the state or any political subdivision thereof for exclusively public purposes, or to any corporation, community chest fund, foundation, or association operating within this state, organized and operated exclusively for religious, charitable, scientific, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net income of which inures to the benefit of any private stockholder or individual, to an amount not in excess of ten per centum of the taxpayer's net income of the calendar or fiscal year as computed without the benefit of this subsection.

* * *

(10) Amounts contributed for the given period to the unemployment reserve fund established in section 108.16 of the statutes, but not the amounts paid out of said fund.

* * *

(12) Any and all sums not to exceed eight hundred dollars paid by any person whose total income shall be three thousand dollars or less by way of

alimony to a former spouse and not to exceed four hundred dollars each for the support of minor children under any order or decree of any court."

B. Index to Deductions

This index is designed to assist the physician in ascertaining what deductions are allowable. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail what deductions and depreciation are allowable.

Automobiles, 1.
  Depreciation.
  Insurance, 1, 4.
  Maintenance.
  Professional use.
  Repairs.
  Salary of chauffeur.
Bad debts, 2.
Bandages, 9.
Conventions, 8.
Depreciation.
  Automobiles—25 per cent annually of cost price, 1.
  Instruments, 9.
    10 per cent annually of cost price of surgical instruments and general equipment; 10 per cent on x-ray equipment.
  Medical library, 6.
    10 per cent annually of cost price.
  Office equipment, 10.
    10 per cent annually of cost price.
Dividends received, 3.
Dues, 12.
Equipment.
  Office, 10.
  Professional, 9, 16(a).
Fire, loss by, 7.
Instruments, 9.
Insurance premiums, 4.
  Automobile, 1.
  Malpractice, 4.
  Professional equipment, 4.
Interest paid, 5.
Laboratory materials, 9, 16(a).
Legal expenses, 16(b), 16(d).
Library, 6.
Licenses, 13.
Losses, by fire, flood, theft, suit, etc., 7, 16(d).
Medical convention, 8.
Medical supplies, 9.
Miscellaneous, 16.
Office expenses, 10.
  Heat, light, supplies, telephone, water, short-lived office equipment, annual depreciation on furnishings and fixtures.
Office rental, 11.
Postgraduate studies, 14.
Professional conventions, 8.
Professional dues, 12.
  County Society.
  State Society.
  Special societies as:
    College of Surgeons.
    College of Physicians.
  Any other paid in interest of profession.
Professional subscriptions, 6.
Salaries, 15.
Sale of spectacles, 16(c).
Scientific meetings, 14.
Subscriptions, 6.
Taxes and licenses, 13.
  Automobile licenses.
  Federal income and social security taxes.
  Import duties, etc.
  Personal property taxes.
  Professional license fees.
  Real property taxes on office owned and used by taxpayer in practice.
  Wisconsin income taxes and surtaxes paid.
  Wisconsin unemployment taxes.
Theft, loss by, 7.
Traveling expenses, 14.
  Both professional calls and scientific meetings.
Wages and salaries, 15.
  Chauffeur, 1.
  Clerk, 15.
  Laboratory assistant, 15, 16(a).
  Maid, 15.
  Nurse, 15.
  Stenographer, 15.
  Any other employe rendering service in connection with taxpayer's practice or in the care and treatment of patients, 15.

C. Explanation of Deductions

In several instances below, references are made to numbered paragraphs of the federal portions of this tax digest. (See p. 1014, Explanation of Deductions.) Such references make it unnecessary to recopy explanatory paragraphs applicable equally to the making of state and federal returns.

1. **Automobiles** (See federal digest, 1).

2. **Bad Debts** (See federal digest, 2).

3. **Dividends Received.** Cash or property dividends received from a corporation's surplus accumulated since January 1, 1911, are deductible by the persons receiving the dividends, if the following requirements are fulfilled:

(a) The corporation paying the dividend must have filed a Wisconsin income tax return for the year preceding the payment of the dividend.

(b) The income of the corporation paying the dividend must have been subject to the Wisconsin income tax law for the year preceding the payment of the dividend.

(c) The principal business of the corporation paying the dividend must have been attributable to Wisconsin for the year preceding the payment of the dividend.

If 50 per cent or more of the entire net income or loss of a corporation, after adjustment for income tax purposes, for the year preceding the payment of

a dividend, was used in computing the taxable income of such corporation, it will be considered that the principal business of such corporation was attributable to Wisconsin.

Note: Stock dividends do not constitute taxable income. Liquidating dividends do not constitute taxable income until the taxpayer has recovered his cost of the stock so held. Any amounts received in liquidation in excess of the taxpayer's cost constitute taxable income.

4. Insurance Premiums. Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. This further includes premiums for various forms of insurance on the building owned and used in connection with the practice, or a fair proportion thereof where the building is also a home. Under professional equipment is to be included an automobile belonging to the physician and used for strictly professional purposes.

5. Interest Paid. Interest paid within the tax year on existing indebtedness may be deducted, provided that the debtor reports the amount so paid, the form of indebtedness, and the name and address of the creditor. No interest is allowed as a deduction if paid on indebtedness created for the purchase, maintenance or improvement of property, or for the conduct of a business, unless the income from such property or business would be taxable under the Wisconsin law.

Interest paid on state and federal income taxes is deductible, but interest paid on fines levied for violations of law is not allowable as a deduction.

Interest paid by an individual on indebtedness created for the purpose of acquiring a home is deductible from gross income. Likewise, interest paid by an individual on money borrowed to pay personal debts, such as hospital bills and other family obligations, is considered a proper deduction from gross income.

Interest paid by an individual on money borrowed for the purpose of securing an education is allowable even though other expenses of obtaining such education are not allowable.

6. Library. A fair rate of depreciation on the physician's library may be deducted covering wear and tear sustained through use. In determining the rate, however, obsolescence may not be considered since the Wisconsin income tax law does not recognize losses in value due to such causes. The fact that medical books become out of date during the course of ten years cannot be considered in determining the rate of library depreciation. An annual depreciation of 10 per cent of the cost of such library seems reasonable, however.

Costs of subscriptions to scientific medical journals essential to keep the physician abreast with the progress of his profession are deductible.

7. Losses by fire, etc. Loss of and damage to a physician's equipment and other property, used by him in connection with carrying on his professional practice, by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent that it has not been made good by repair and cost of repair claimed as a deduction. Losses on business conducted or property located outside the state are not deductible.

Losses on automobiles, aircraft, summer homes, motor boats, furniture, etc., purchased and held for pleasure are deductible from gross income where sustained because of theft, fire, flood, or other casualty. Losses on property used for both pleasure and practice are deductible only to the extent that such property was used in the practice, unless such losses were sustained through fire, flood, other casualty, or theft, in which cases the entire loss is deducted.

8. Medical Conventions. Ordinary and necessary expenses incurred in attending medical conventions of professional scientific societies necessary to enable the physician to carry on his profession, are deductible.

Costs of attending professional conventions must be strictly limited to the necessary cost and expense directly attendant upon such conventions. The type of professional convention here contemplated is confined to such as are, as a general rule, ordinarily and generally attended by persons of the same professional standing as the taxpayer, as necessary to the maintenance and carrying on of their regular practice and profession.

9. Medical Supplies and Instruments (See federal digest, 4).

10. Office Expenses (See federal digest, 5).

11. Office Rental. If a physician pays rent to another person for office space he is permitted to deduct the amount from his gross income. This includes office space in a rented home, provided office hours are maintained. Where a physician maintains his offices in the home which he occupies as a residence, he may, if the home is rented, deduct as rent that proportion of the total rent paid which the value of his office space bears to the rental of the entire premises; and if he owns the residence, he may deduct the proper share of expenses attributable to the space so occupied, including taxes, depreciation, insurance, water, light, heat, repairs and general upkeep.

12. Professional Dues. Professional dues paid to professional associations to which the physician may belong in the interest of his profession may be deducted.

13. Taxes and Licenses. All taxes and licenses incident to the professional scope of the physician may be deducted. The following taxes would be deductible by any physician:

(a) Real property taxes paid on office owned by him and used by him in his practice.

(b) Personal property taxes paid on his apparatus and equipment.

(c) Wisconsin income taxes and surtaxes paid.

(d) Federal income taxes, provided that such deductions are limited to taxes paid in cash within the year covered by the income tax return on net income taxable under the Wisconsin law.

(e) All license fees incident to his profession.

(f) Automobile licenses on automobiles used exclusively in the practice of his profession. See paragraph 1 supra.

(g) Import or tariff duties and business, license, privilege, excise, and stamp taxes, are deductible if incurred in connection with the carrying on of the taxpayer's practice and profession.

(h) All social security taxes paid by the physician under Titles VIII or IX in his capacity of employer and the amount paid by him under the Wisconsin unemployment compensation act. The Wisconsin rule up to this time has not permitted the salaried physician to deduct on his state income tax return the 1 per cent deducted from his salary as his social security contribution. This point is now pending before the State Board of Tax Appeals, however, and the ultimate ruling either by this board or by a court cannot be given at this time.

14. Traveling Expenses (See federal digest, 9).

15. Wages and Salaries (See federal digest, 10, and state digest 16(e) below).

16. Miscellaneous.

(a) Laboratory Expenses (See federal digest, **11(c)**).

(b) Legal expenses incurred in the defense of a suit for malpractice are deductible as business expense. Expenses incurred in the defense of a criminal action, however, are not deductible.

Legal expenses incurred in connection with the operation of a taxpayer's profession are proper deductions unless such business is conducted in violation of the law.

(c) Sale of Spectacles (See federal digest. 11(e)).

(d) Unclassified. Payments required to be made to others for damages growing out of the carrying on of the profession such as injury to property, interference with property rights, breach of contract, and libel are deductible from gross income. Damages of a personal character recovered against the physician, such as those for the surrender of the custody of a minor child, are not deductible from gross income because not related to the carrying on of the physician's profession.

Miscellaneous expenses which are incurred in producing taxable income and are allowable deductions include the following: fees paid to auditors, tax experts, and lawyers in connection with income tax matters, welfare work expense incurred in keeping up the morale in an organization.

(e) Informational Returns. All salaries, wages, fees, or other compensation for services actually rendered in connection with the physician's practice, including fees to independent contractors such as attorneys or accountants, which total or exceed $700 in the case of any individual recipient, must be reported or such expense shall not be deductible. This information, which must disclose the name, the address and the amount paid each such person, can either be furnished as a part of the income tax return or reported on form 9A, which form will be furnished the physician by the income tax assessor on request. Similar information must be furnished either on the return or on form 9A which should accompany the return, where deduction is sought on items of rent, royalty and interest expense.

"DOCTORS AT WORK"

Arrangements have been made with the National Broadcasting Company for audiences to witness the broadcasts of the American Medical Association—National Broadcasting Company radio program DOCTORS AT WORK.

The program is in dramatic form, requiring ordinarily six actors; sound effects equipment and personnel; announcer, and orchestra.

Wisconsin physicians contemplating visits to Chicago may procure tickets to the broadcast by addressing a request, stating the date desired and a possible alternate date, to the Bureau of Health Education, 535 North Dearborn St., Chicago. Tickets are free. Ordinarily request should be limited to two tickets, but in special circumstances larger numbers may be available.

Programs are broadcast Wednesday night, at 9:30 p. m., central standard time, in the studios of Radio Station WENR, 19th floor, Merchandise Mart, Chicago.

Inheritance and Estate Taxes

LIKE other branches of tax law, those dealing with state inheritance and federal estate taxes are mounting both in their complexity and their rates. The points indicated below are not intended to be comprehensive or exhaustive, but rather to indicate to the physician, in broad outline, some of the general problems involved in those taxes, so as to aid him in planning his estate.

Federal Estate Tax

The federal estate tax is based on the right of an individual to *give* away the property which he accumulates, as distinguished from the right on the part of his beneficiary to *receive* such property. Among the principal points of interest to the physician in connection with the federal estate tax are the following:

1. *Liability to file return.*—If the gross estate—that is, the total valuation of all assets before deducting debts, expenses of administration, taxes, etc.—is $40,000 or less, no estate tax return need be made by the executor or administrator of the estate of a deceased. If more than $40,000, such a return must be made.

2. *Exemption of $40,000 of general assets.*—After the net estate has been determined, by which is meant the gross valuation of all assets less all debts, expenses of administration, certain taxes and other items, an exemption of $40,000 is allowed before any tax liability accrues.

Example:

Valuation of gross assets	$60,000
Total of debts and other deductions	10,000
Net value of estate	50,000
Amount subject to tax after subtracting exemption of $40,000	10,000

3. *Insurance exemption of $40,000.*—Insurance on the life of the deceased revocably assigned by him to beneficiaries other than his estate is exempt from estate tax to the extent of $40,000. This insurance exemption is independent of and in addition to the $40,000 exemption on general assets of an estate, referred to in paragraph 2, immediately above. By the term "revocably assigned insurance" is meant the designation in a policy of beneficiary by the insured person under a provision attached to the policy which permits the policyholder to change the beneficiary at any time.

Example: Dr. Smith dies, leaving in life insurance, $50,000 payable to his wife, and $25,000 payable to his son, or a total of $75,000. Of this total $40,000 is exempt from estate tax, but as to the remaining $35,000 the estate is subject to tax, if that amount, when added to the doctor's net general estate (by which is meant his net assets other than insurance) exceeds $40,000.

An exception to this exemption is a situation in which a policy is assigned for the actual or ultimate benefit of the assured person or his estate, even though the named beneficiary is someone other than the estate.

Example: At the time of Dr. Smith's death a $10,000 policy which he carried on his life was assigned to a bank to help secure a $5,000 loan. Five thousand dollars of the insurance proceeds are actually turned over to the bank and the remaining $5,000 to Dr. Smith's widow. The $5,000 received by the bank is subject to an estate tax if the net value of the remainder of Dr. Smith's general estate, added to such amount, exceeds $40,000.

4. *Insurance to estate non-exempt.*—Any insurance which the deceased made payable to or for the benefit of his estate, to provide money for taxes, debts, legacies, or any other purpose, is all subject to tax if the net amount of the estate exceeds $40,000.

5. *Irrevocably assigned insurance exempt.*—Insurance on the life of a deceased which was irrevocably assigned to beneficiaries other than his estate is wholly exempt from taxation if—

(a) The insurance was not assigned as a gift in contemplation of, or to take effect at, his death.

(b) The beneficiary paid the premiums on the insurance out of funds of his own which did not come to him from the insured either directly or by gift or trust established in his favor by the insured.

By the term "irrevocably assigned insurance" is meant the designation in a policy by the insured person of a person or persons as the beneficiaries of the policy without reservation in the insured of the privilege of changing the beneficiaries at any future date. This has the legal effect of vesting in the beneficiaries irrevocably designated all property rights to the policy.

6. *Joint interests taxable.*—Any property held by a physician and another, or others, jointly, is included in his gross estate to the extent of the physician's title or other interest in such property. Determination of the physician's *actual* interest where that varies from his *declared* interest is subject to technical rules which need not be detailed here. Thus if his *declared* interest as joint tenant in certain land acquired by purchase is shown by the deed to be one-third, whereas his *actual* financial interest is two-thirds, the land will be appraised in the inventory of his estate at two-thirds of its full value.

Wisconsin Inheritance Tax

The Wisconsin inheritance tax is based on the right to *receive* property from the estate of a decedent in contrast to the basis for the federal tax, above noted, which is on the right to *give*. The practical effect of a tax on the right to inherit, such as Wisconsin's, is that each legacy or other share in the estate of a deceased is subject to tax

to the extent that it exceeds the statutory exemptions, and the beneficiary gets only the net amount. Thus if a bequest of $5,000 is left by will to a beneficiary and the inheritance tax on it is $300, such beneficiary will receive only $4,700 from the estate, the other $300 being retained for payment of the tax. This result can be avoided by provisions in the will that designated gifts are to be paid in their full amount to those designated, the estate to carry the amount of the tax. Below are indicated several points which it is hoped will assist the physician in estimating broadly his liability under the Wisconsin inheritance tax law.

1. *Liability to file return.*—Unless it is apparent from the final account rendered by the administrator or executor of an estate to the probate court that the estate is nominal in value, or that the net amount of any share of the estate will fall substantially short of the exemptions allowed by statute, as indicated in paragraph 2 immediately following, every administrator or executor must make an inheritance tax return to the state department of taxation.

2. *Tax exemptions.*—The following amounts received from estates are exempt: $15,000 received by a widow from the estate of her husband; $5,000 received by a widower from the estate of his wife; $2,000 where the relation of the beneficiary to the decedent is that of child, parent, brother, sister, descendent of brother or sister, daughter-in-law, son-in-law, or a child adopted under certain conditions. A $250 exemption is allowed where the relation of the beneficiary to the decedent is that of uncle or aunt or the descendent of an uncle or aunt. An exemption of $100 is allowed where the relation of the beneficiary to the decedent shall be that of any other degree than those stated above, or he shall be a stranger in blood to the decedent.

3. *Insurance exemption of $10,000.*—Under a 1939 amendment, insurance up to $10,000 on the life of a decedent, payable to a beneficiary or beneficiaries other than the estate of the insured is exempt from inheritance tax. This exemption is in addition to that allowed those same beneficiaries if they should receive any of the general assets of the estate, as indicated in paragraph 2 immediately above.

Each beneficiary of such insurance, other than the estate of the insured, is entitled to a portion of the total exemption of $10,000 based on the ratio that the value of the insurance payable to him bears to the value of the total insurance payable to all beneficiaries other than the estate.

Example: Dr. Smith dies and leaves $10,000 in insurance payable to his estate and a $10,000 policy to each of his five children, or a total of $60,000. The $10,000 policy payable to his estate is not included within the $10,000 exemption above, and may be disregarded for purposes of its computation; $2,000 would be exempt on each of the five policies of $10,000 to each of his children, and a tax would be payable on $8,000 of each of those policies. The $8,000 subject to tax in each instance would be added to any other share of such beneficiary in the general assets of the insured's estate and only one tax assessed.

4. *Insurance payable to estate non-exempt.*—No insurance payable to the estate of the insured person is exempt from the Wisconsin inheritance tax. It is included in the general assets of the estate, and whether a tax will ultimately be paid on it will depend entirely on whether the share going to each of the beneficiaries of the estate exceeds the statutory exemption.

5. *Irrevocably assigned insurance exempt.*—Insurance payable on the death of any person which is irrevocably assigned to a beneficiary other than the estate of the insured, so that the insured retains no legal incidents of ownership in such insurance is exempt from inheritance taxation. By "legal incidents of ownership" in an insurance policy are meant the right of the insured or his estate to its economic benefits, the power to change beneficiary, to surrender or cancel the policy, to revoke it for an assignment, to pledge it for a loan, or to borrow on it against the cash surrender value.

The exception to this general rule would be an irrevocable assignment of insurance made by the assured in contemplation of his death, which would be included in his gross estate.

Further applying the statute, if an insurance policy was carried on Dr. Smith's life, even though his wife paid the premiums on the policy out of her own income, the face amount of the policy would be subject to state inheritance tax after the doctor's death, if he had during his life retained any of the "legal incidents of ownership" in the policy as that term is above defined.

6. *Joint interests taxable.*—Any property jointly held by the physician and another or others is subject to tax to the extent of the deceased's declared joint interest in such property.

Example: Dr. Smith and his wife own as joint tenants a farm worth $20,000 at the time of the doctor's death. Dr. Smith's interest is computed as one-half of that valuation or $10,000, in his gross estate, and that amount will be deducted from the $15,000 which will be exempt in the hands of Mrs. Smith as his widow.

BULLETIN OF WAR MEDICINE

As a part of its contribution to medical preparedness, the Medical Research Council of Great Britain has made available a publication called the *Bulletin of War Medicine*, which is a collection of abstracts dealing with the handling of many military-medical affairs, taken from the available medical literature. The first number consists of 62 pages containing 109 abstracts. This Bulletin is available to American readers by addressing the British Library of Information, 50 Rockefeller Plaza, New York. The price is 75 cents per copy.

Summary of Wisconsin Poor Relief Laws Affecting Care of Indigent Sick

A Digest of Laws, Rulings and Practices

In the administration of relief, the following rulings are applicable and must be followed by relief officials:

1. **Blind Pensioners.** Blind pensions are granted in proper cases under the provisions of chapter 47 of the Wisconsin Statutes. Such a pension is a gratuity by the state in which the recipient has no vested right. But, on the other hand, neither can the county officials seek to control its expenditure after it reaches the control of the recipient. See: 24 Opinions Attorney General 109. In determining the amount of blind pensions, officials may take into account medical and surgical needs, but if the total assistance granted is not adequate for medical and surgical needs, then medical and surgical relief shall be extended through regular relief channels for there is no provision in the law providing for the expense of medical and surgical care out of the funds available for pensions, and consequently such assistance must be extended under the general relief provisions of Chapter 49, or, in proper cases, under the provisions of Chapter 142, the Wisconsin General Hospital Law.

2. **Old Age Assistance or Pensions.** In determining the amount of old age assistance aid, officials may take into account medical and surgical needs; the total aid received from such old age assistance officials shall not, however, exceed a total of $40 a month. If the assistance granted is not adequate for the medical or surgical needs, then medical and surgical relief shall be extended through the regular relief channels. See: 25 Opinions Attorney General 287 and 26 Opinions Attorney General 306.

3. **Aid to Dependent Children (Mothers' Pension).** Medical and dental care is available from the pension funds not only for the child, but in the discretion of the pension agency for the father, if incapacitated, and the mother. Section 48.33 (6), Wisconsin Statutes. Maternity aid, in the form of supplies, nursing, medical or other assistance, shall be granted during the period from six months before to six months after the birth of a child, if the financial condition of the mother is such as to deprive her or the child of proper care. Section 48.331, Wisconsin Statutes.

The granting of aid for dependent children does not prevent the relief unit from furnishing medical aid in proper cases. See: 20 Opinions Attorney General 146.

4. **W. P. A. Employes.** The fact that an individual in need of medical care which he has not the means to purchase, is employed on a W. P. A. project does not relieve the proper relief officials from extending him that care. The sole question is whether he has sufficient funds to secure such services for himself. If not, he is entitled to assistance through regular relief channels. See: 24 Opinions Attorney General 802 and 26 Opinions Attorney General 610.

IMPORTANT: **There is no "no-man's land" in matters involving relief.** No matter if the applicant is working and is possessed of sufficient means to provide the ordinary daily necessities of life, if that individual has need of medical care for himself or family which he cannot himself secure, he is entitled to have the assistance of relief officials. See: Coffeen v. Town of Preble, 142 Wis. 183. Thus it has been held the duty of relief officials to supply liver extract to one, suffering from pernicious anemia, whose means were insufficient to purchase that item, although sufficient for other purposes. See: 20 Opinions Attorney General 162. In another case involving similar circumstances, the Attorney General held the furnishing of insulin proper. See 18 Opinions Attorney General 8.

The responsibility of relief authorities to provide relief to those in necessitous circumstances is mandatory by statute and by decisions of the Wisconsin Supreme Court. See: Meyer v. Prairie du Chien, 9 Wis. 233; Elkey v. Seymour, 169 Wis. 223.

Failure of relief officials to render aid is misconduct for which they are "amenable in some action." Patrick v. Town of Baldwin, 109 Wis. 342. Unless the funds are insufficient, poor relief officials' wilful failure to care for a needy person subjects them to criminal prosecution as well as personal liability. 21 Opinions Attorney General 1141.

SUMMARY OF POOR RELIEF LAWS

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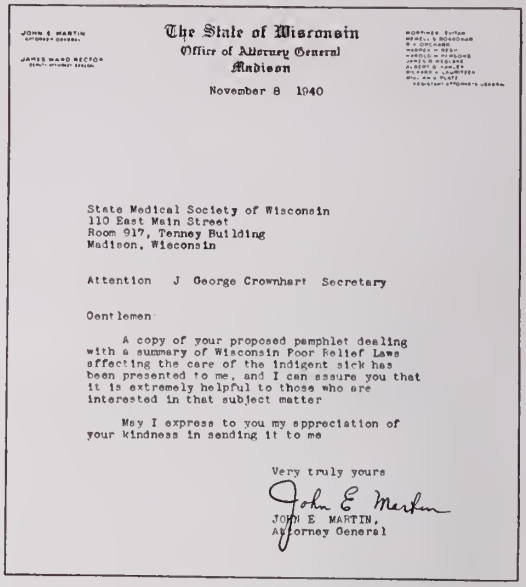
Milwaukee County Physicians Please Note!

Because of various exemptions in the laws and the separate institutions in Milwaukee county, this digest is not applicable in general practice in Milwaukee county, as it relates to the authorization of physicians to care for the sick.



JOHN E. MARTIN
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The State of Wisconsin
Office of Attorney General
Madison

November 8 1940

State Medical Society of Wisconsin
110 East Main Street
Room 917, Tenney Building
Madison, Wisconsin

Attention J George Crownhart Secretary

Gentlemen

A copy of your proposed pamphlet dealing with a summary of Wisconsin Poor Relief Laws affecting the care of the indigent sick has been presented to me, and I can assure you that it is extremely helpful to those who are interested in that subject matter

May I express to you my appreciation of your kindness in sending it to me

Very truly yours

John E Martin

JOHN E MARTIN,
Attorney General

IN THE absence of statute, there would be no legal obligation on the part of a municipality to relieve the poor. Meyer v. Prairie du Chien, 9 Wis. 233, and Patrick v. Baldwin, 109 Wis. 342.

In the Wisconsin statutes of 1849 it was provided that, "Every town shall relieve and support all poor and indigent persons lawfully settled therein, whenever they shall stand in need thereof." The provision is but little changed today. To a large extent, revision of the poor law has dealt, not with the betterment of relief, but with the problem of who shall pay for the relief.

The history of poor relief is rife with neglect and misunderstanding. In Mappes v. Board of Supervisors, 47 Wis. 31, 35, the court said: "But in taking leave of the case, we are constrained to say that the ingratitude of the children of this aged pauper, and the neglect of the public authorities in discharging their duties in respect to her, are complimentary neither to the affection and filial duty of the former, nor to the humanity and public duty of the latter. 'Man's inhumanity to man' is not a mere figment of poetic genius."

Poor relief officials, however great their zeal, are hampered in the performance of their duty by lack of training in poor relief, unfamiliarity with the interpretation of laws, and justifiable fear of criticism if they err on the side of humanity at the expense of the public funds. Each new set of town, village, city, and county officials, in each of the many governmental subdivisions of the State, view the poor relief laws and their duties under them from a different point of view. The wonder is, not that poor relief has failed of perfection, but that it has made progress at all.

From court decisions, attorney generals' opinions, and other available authorities, certain principles have become established, certain rules laid down. Innumerable problems have been met and decided.

It is the aim of this discussion to set forth the answers to such perplexing questions as seem settled, as well as to briefly digest a large part of the poor relief law, to the end that those working under it may have a more definite understanding of their duties, liabilities, and rights.

1. Relief is Mandatory

Section 49.01 of the Wisconsin statutes requires that each town, village and city "shall" relieve and support all poor and indigent persons lawfully settled therein. The statute is mandatory. Meyer v. Town of Prairie du Chien, 9 Wis. 233. An action will lie to compel the performance of a duty by officials. State ex rel. Owen v. Stevenson, 164 Wis. 569. State ex rel v. Zimmerman, 183 Wis. 132, 150. If poor officials fail to render aid "they are doubtless amenable in some way for such misconduct." Patrick v. Town of Baldwin, 109 Wis. 342, 354.

Where the necessity for aid is urgent and the afflicted person poor, indigent, and helpless to such a degree that obtaining relief without town aid in time to save life or health may be impossible, it cannot be said as matter of law that he is not entitled to relief from the town merely because he possesses some meager property not immediately available for conversion into cash or as a basis of credit. Coffeen v. Town of Preble, 142 Wis. 183.

2. Legal Settlement

Legal *settlement* and legal *residence* should not be confused; they are not synonymous. 22 Atty. Gen. 929; 24 Atty. Gen. 711.

Legal settlement for poor relief purposes must be in a town, city or village. But the county may be used as the unit of settlement for other purposes (as basis of aid to dependent children, 27 Atty. Gen. 285). And for some purposes settlement may be in *two* counties (apportionment of cost of hospitalization of tubercular person, 27 Atty. Gen. 529). Legal settlement and residence for school purposes may differ. 27 Atty. Gen. 326.

Section 49.02, Wis. Stats., states how legal settlement is acquired. In brief:

Any Adult: By residence in the municipality one year.

Wife: Her settlement is that of her husband. If he has none, then her settlement is the one she had at the time of marriage, unless she has since acquired a new one.

Husband: By one year's residence. If he has none, and his wife has one, he may be granted relief at her place of settlement.

Minors:

Legitimate children: Their settlement is that of the father, if he has one; otherwise, that of the mother.

Illegitimate children: Their settlement is that of the mother at the time of birth. (Even though she subsequently changes her settlement. 27 Atty. Gen. 469.)

If neither parent has a settlement, a child may acquire settlement by one year's residence.

A minor bound as an apprentice takes immediately the settlement of the master.

Settlement is not gained in the place of birth by birth unless a parent had settlement there.

Emancipation of a minor does not make him "of age" in the matter of gaining legal settlement. Town of Grand Chute v. Milwaukee County, 230 Wis. 213; also La Crosse County v. Vernon County, 290 N. W. 279.

Loss of Settlement:

By voluntary and uninterrupted absence for one whole year.

Receipt of aid breaks the running of the year, so that one does not lose legal settlement if he receives relief while absent from his place of legal settlement. Town of Cleveland v. Industrial Commission (Wis.), 286 N. W. 558.

Reorganization (attachment or division) of a municipality: Settlement follows the territory, as does also any period of residence towards the acquiring of a settlement.

A Foreigner:

May acquire a legal settlement so as to entitle him to poor relief. 4 Atty. Gen. 660; 20 Atty. Gen. 801.

May be deported. 23 Atty. Gen. 227.

A settlement cannot be acquired while being supported as a pauper. Scott v. Clayton, 51 Wis. 185; 11 Atty. Gen. 419; 13 Atty. Gen. 503; 22 Atty. Gen. 922; 27 Atty. Gen. 777.

Question of pauper status is one of fact. Support by relatives or friends does not necessarily classify one as a pauper. Town of Ellington v. Industrial Comm., 225 Wis. 169. But pauper status may continue after public support ceases if one had not thereafter been self-supporting. See: Town of Rolling v. Antigo, 211 Wis. 220; Town of Holland v. Belgium, 66 Wis. 557, and Monroe County v. Jackson County, 72 Wis. 448.

Receiving of old-age pension prevents gaining legal settlement. 24 Atty. Gen. 163; 27 Atty. Gen. 576. Receipt of blind pension also prevents gaining legal settlement. 27 Atty. Gen. 51.

Legal settlement cannot be acquired by person under legal restraint (in prison). 21 Atty. Gen. 893. Settlement is not lost by imprisonment, even though imprisoned in another state. 22 Atty. Gen. 786.

No relief unit of this state need support one who has removed to another state while such person resides there. 21 Atty. Gen. 363.

Person living in automobile trailer with his family may acquire legal settlement. 28 Atty. Gen. 696.

The Attorney General has ruled upon the question of legal settlement in innumerable instances, based upon the particular facts of each case. Space does

not permit a digest of these opinions, but reference to them is given and they may be classified as follows:

Minors: 21 Atty. Gen. 547, 643, 709, 759, 780, 1095; 22 Atty. Gen. 75, 110, 116, 225, 279, 363, 592, 680, 977, 1041; 23 Atty. Gen. 105, 475, 580, 680, 684, 755, 796, 825; 24 Atty. Gen. 5, 583, 602; 25 Atty. Gen. 430, 686, 745; 27 Atty. Gen. 574; 28 Atty. Gen. 65; 28 Atty. Gen. 675; 29 Atty. Gen. 80, 159, 293.

Wife or mother: 20 Atty. Gen. 170; 20 Atty. Gen. 231, 244, 320; 21 Atty Gen. 752, 780; 22 Atty. Gen. 75, 128, 140, 363, 593, 665, 944, 1041; 23 Atty. Gen. 113, 475, 580, 617, 755; 24 Atty. Gen. 110; 25 Atty. Gen. 430.

Effect of removal order: 29 Atty. Gen. 141.

Effect of C. C. C. employment: 29 Atty. Gen. 165.

Miscellaneous: Husband, single person, transient, etc.: 20 Atty. Gen. 622, 1144; 21 Atty. Gen. 119, 186, 318, 390, 621, 707, 780, 846, 893, 979, 983; 22 Atty. Gen. 25, 45, 75, 145, 147, 155, 222, 302, 424, 435, 665, 680, 771, 786, 802, 845, 909, 922; 23 Atty. Gen. 314, 382, 527, 541, 702, 744, 820; 24 Atty. Gen. 9, 112, 163, 190, 221, 251, 416; 24 Atty. Gen. 719; 25 Atty. Gen. 718; 26 Atty. Gen. 28, 472, 574; 27 Atty. Gen. 51, 177, 183, 198, 576, 708; 28 Atty. Gen. 675.

3. Transient Pauper

A transient pauper is one who is in a municipality wherein he has no legal settlement.

(Doubt is expressed whether "professional tramps" are entitled to poor relief. Vagrancy is itself an offense by law and it would therefore be inconsistent to consider it as indigency. 21 Atty. Gen. 517.)

He is entitled to relief:

If he furnishes a sworn statement as to his legal settlement, the municipality furnishes the relief. Sec. 49.03.

If he does not furnish such sworn statement as to legal settlement, the relief must be furnished by the county, under section 49.04, Wis. Stats. 20 Atty. Gen. 1248. The requirement as to sworn statement was placed in the law in 1929; prior to that time, the municipality furnished the relief. 19 Atty. Gen. 74. See also Milwaukee County v. Sheboygan, 94 Wis. 58, and Ebert v. Langlade County, 107 Wis. 569.

The expense of relief is billed against the county, which in turn bills the county of his legal settlement, and that county bills the municipality of his settlement. 22 Atty. Gen. 699.

If the pauper has no legal settlement, or none that can be ascertained, the county must furnish his relief. Sec. 49.04. 20 Atty. Gen. 1248; 22 Atty. Gen. 730, 918; 26 Atty. Gen. 538.

The clerk of the municipality which renders the relief shall, if possible, ascertain the place of legal settlement, and shall, within ten days from the date the person becomes a public charge, serve a written notice on his county clerk, stating the name of the person, the municipality of his legal settlement, or that it could not be ascertained, and the date on which aid was commenced. The notice may be given after ten days, but in that event the county is liable for the cost of the relief only from the time of the giving of the notice. The county clerk must give notice to the county clerk of the county of settlement within ten days after he gets notice. He may give the notice after that time, but in that event the county of settlement is liable for the cost of relief only from the time of the giving thereof. 20 Atty. Gen. 1034.

Under Sec. 49.03 (9) upon application to the county judge or municipal judge, made either by the municipality rendering the relief or the municipality of legal settlement, the judge may make an order requiring the pauper to remove to his legal settlement, "unless it shall clearly appear that his removal would be against his best interests." The cost of removal is chargeable to the municipality of legal settlement. Refusal of the pauper to obey an order of removal subjects him to loss of the right to relief until he does comply. See 22 Atty. Gen. 771; 23 Atty. Gen. 730; 25 Atty. Gen. 686.

Quarantine; removal not considered as being to best interest of patient. 27 Atty. Gen. 532.

Sec. 143.05 (10) provides procedure for indigent quarantine cases. There should be no conflict between that section and 49.03 (9) in practical administration of the two. 27 Atty. Gen. 532. See Title 13, this digest.

If the "county system" of poor relief is in effect in the county of legal settlement, that county is chargeable with the expense of relief.

If the "county system" is in effect in the county where the relief is rendered, the relief is, of course, given by the county instead of by the town, city or village. Sec. 49.15.

One who has lost his legal settlement and not acquired a new one must be supported by the county of his *residence*. 20 Atty. Gen. 1264.

One who is brought from one county into another, in order to receive hospitalization, is not a transient so as to render the latter county responsible for such hospitalization, nor does his legal settlement change. 19 Atty. Gen. 325.

What relief unit pays? The following opinions deal with this question: 22 Atty. Gen. 699, 875, 914, 952, 1005; 23 Atty. Gen. 175, 183, 221, 283, 321, 439, 820; 24 Atty. Gen. 125, 202, 384, 438; 26 Atty. Gen. 538, 610; 27 Atty. Gen. 214; 28 Atty. Gen. 1, 27.

Miscellaneous opinions relating to transients: 22 Atty. Gen. 802, 909, 935.

4. Who is Entitled to Relief

It is the duty of the poor authorities to grant relief when the circumstances are such that the poor person has not the means or credit presently available with which to secure all the necessities of life. Elkey v. Seymour, 169 Wis. 223.

The ownership of property upon which funds cannot be presently raised to furnish necessities does

not bar right of relief. It goes only to the question of reimbursement of the municipality for relief given. Elkey v. Seymour, 169 Wis. 223.

In 1931, section 49.01 was amended to provide that, "The ownership of a home or an equity therein shall not bar the granting of relief, in the discretion of the authorities in charge of such relief, to any person who by reason of unemployment or sickness stands in need of such relief."

Under a common rule of statutory construction, *expressio unius est exclusio alterius*, the amendment might easily be interpreted as narrowing the statute, rather than broadening it. Under a narrowed interpretation, one owning a home but not unemployed or not sick would not be entitled to relief, even though in most dire need and even though the home could not be presently used to raise means or credit to supply necessities. Likewise, under narrow interpretation, the ownership of any property might bar relief, contrary to the rule laid down in the Elkey case cited above.

But it is not believed that the legislative intent was to narrow the statute. On the contrary, keeping in mind the background of 1931 legislation, the business depression, a vast amount of unemployment, reduced income, and the innumerable bills introduced in the legislature for the relief of those affected by unemployment and reduced income, it seems more reasonable to conclude that the legislature intended to *broaden* the statute, so that one need not mortgage his home if unemployed or sick.

Sec. 49.025 was enacted in 1933, and provides that no person shall be denied relief because of owning an equity in a home in which he lives or by reason of having an insurance policy with a cash value of not to exceed $300; and no applicant for relief shall be required to assign such equity or insurance policy as a condition for receiving relief. 22 Atty. Gen. 760; 25 Atty. Gen. 104.

In 1937, Sec. 49.01 was further amended so as to authorize relief authorities to pay the interest on a mortgage on a homestead, when by so doing it will cost less than the authorities would have to expend for shelter. In 1939 the statute was further amended to permit payment of taxes and interest on a mortgaged homestead.

The authorities are without power to require a needy person, as a condition of relief, to contract to reimburse the town or county and to convey present or future property as security therefor. 21 Atty. Gen. 596; 22 Atty. Gen. 261, 277; 25 Atty. Gen. 673. However, in Estate of Pelishek, 216 Wis. 176 it was held that under Sec. 49.10 the unit furnishing relief might recover the amount thereof from a recipient of such relief who later comes into funds or property. It was otherwise held in the case of Guardianship of Decker, 181 Wis. 484, which was decided in 1923. The legislature changed the law to subject after-acquired property to this liability by Ch. 118, Laws of 1925.

A minor having estate resulting from damages for personal injuries is not indigent so as to be entitled to relief, although his parents are indigents. 28 Atty. Gen. 401.

The county may require work of applicants for poor relief. 22 Atty. Gen. 277; 25 Atty. Gen. 137.

An alien indigent is entitled to relief (20 Atty. Gen. 801), but may be deported upon proof that he is a pauper. 20 Atty. Gen. 338; 23 Atty. Gen. 227.

Indians are entitled to poor relief under the state poor relief laws. 20 Atty. Gen. 498. Indians who are still members of Indian tribes are entitled to such relief. 20 Atty. Gen. 534; 23 Atty. Gen. 680. Also persons of mixed blood, even though living on reservation. 23 Atty. Gen. 314.

5. Extent of Relief

The relief required to be given must be coextensive with the person's necessities; that is, whatever he may lack of food, clothing, lodging, medicines, medical attendance, nurse, or hospitalization, must be furnished. For example:

The person has sufficient means to feed his children but not to clothe them. The poor authorities must furnish clothes.

Or he has means to furnish all the ordinary necessities, but requires a surgical operation for which he is unable to pay. He is entitled to such operation at public expense.

Or he has means to furnish ordinary necessities but requires expensive medicine costing beyond his means, such as insulin. He is entitled to it at public expense.

18 Atty. Gen. 8; 20 Atty. Gen. 140; 20 Atty. Gen. 162.

School tuition should be furnished. 23 Atty. Gen. 252; 24 Atty. Gen. 602; 25 Atty. Gen. 290.

The furnishing of employment under Reconstruction Finance Corporation and industrial commission outdoor relief plan constitutes relief within the meaning of chapter 49 of the statutes. This is also true where rent, food, etc., is furnished to the recipient and he is given employment to the value of such supplies. 22 Atty. Gen. 198 and 218.

W. P. A. worker's family is entitled to medical aid and hospitalization. Atty. Gen. Dec. 23, 1935. 24 Atty. Gen. 802. "Your county is operating under the county system of relief. The head of a family is working on a W. P. A. project and is receiving forty dollars per month from the federal government.

"You ask whether the members of his family are entitled to medical aid and hospitalization from the county.

"The furnishing of medical aid and hospitalization in no way depends upon the fact as to whether a person is entirely destitute. The essential question is: Has the person sufficient means to furnish such needs for himself? Coffeen v. Town of Preble, 142 Wis. 183. In 20 Atty. Gen. 162 it was held that it is the duty of a town under the town system of poor relief to provide all medical relief for which a person has no means to provide himself, although he may be able to provide all other means of existence;

this includes furnishing of liver extract over a long period of time in case of pernicious anemia.

"See also 18 Atty. Gen. 8, in which it was held that a poor commissioner has power to furnish a daily supply of insulin to a person affected with diabetes, even though such person is capable of supporting himself in all other respects."

Misc. op.: 26 Atty. Gen. 610.

6. Two Systems

There are two systems of poor relief: (1) The "town" system, under which each town, village and city relieves the poor within its boundaries; (2) the county system, under which the county has elected to take charge of poor relief.

See 28 Atty. Gen. 514 for discussion of rendering of relief in case territory is transferred from one county to another.

The law does not authorize a county to handle poor relief part under the county system and part under the town system. 22 Atty. Gen. 189, 1005 and City of Washburn v. Bayfield (Wis. 1940), 292 N. W. 912, also Legault v. Owen (Wis. 10–8–40).

The county system is established by resolution of the county board and may be abolished in the same manner. Secs. 49.15 and 49.16. 25 Atty. Gen. 533; 27 Atty. Gen. 252.

There is express authority, under the county system, for the establishment of the office of superintendent of the poor. (Sec. 49.14). But this provision is not a restrictive one, and the county is given full power to care for the poor in some other manner. Misc. op.: 24 Atty. Gen. 633.

In cities (Sec. 62.09) and villages (Sec. 61.34), there appears to be no question but what the council or board may delegate the duty of caring for the poor to a poor commissioner.

As to towns, the right to appoint a poor commissioner is not clear. Sec. 60.29. The town board is charged with "all affairs of the town not by law committed to other officers." The specific authority in that section for the town board to appoint a night watchman, policeman, a superintendent of police, etc., negatives the right of the town to appoint other officers or agents, and tends to the view that poor relief is a duty imposed upon the board itself. Misc. op.: 24 Atty. Gen. 269.

When poor relief is properly delegated to a commissioner, his authorization for the rendering of relief is, of course, sufficient authority to charge the municipality.

But a superintendent or board of trustees authorized to care for the poor may not expend funds in excess of the amount budgeted to them for the purpose. However, the exhaustion of such a fund does not relieve the municipality of its duty to relieve the poor. 19 Atty. Gen. 521. 24 Atty. Gen. 384. It follows, then, that after the poor commissioner's fund is exhausted, authority to render relief should be secured as in municipalities where there is no poor commissioner,—that is, from the chairman, village president, etc., in emergency cases, and from the board or council in other instances.

Where the county system is in force, the county is charged with all the duties of the town, village, or city, with reference to poor relief. Sec. 49.15. Municipalities may contribute. 23 Atty. Gen. 504.

By reason of quarantine expense being on the town, village or city, under the provisions of Sec. 143.05, Stats., preventive serums and measures must be paid for by the town, village or city, even though the county system of poor relief is in force. For instance, the cost of the Schick test and serums used to immunize a quarantined indigent must be borne by the town, city or village; other medical care must be at the expense of the municipality liable for poor relief, even though the person be under quarantine. 21 Atty. Gen. 303; 25 Atty. Gen. 514.

By Chapter 14, Sec. 7, Laws of Special Session 1937, standards of aid and eligibility for relief shall be determined by the local unit of government administering relief.

By Chapter 435, Laws of 1939, all duties imposed on the Industrial Commission by Chapter 363 of the Laws of 1933, were transferred to the Department of Public Welfare.

The Department of Public Welfare is given authority to hear and decide claims between poor relief units for relief rendered. Sec. 49.03 (8a).

Poor relief is purely a matter of statute. Municipal corporations hold their powers from the state, which has full power to prescribe the method of furnishing poor relief and what municipality shall be liable therefor. The statute giving the Industrial Commission the duty of determining disputes between relief units was upheld in Holland v. Cedar Grove, 230 Wis. 177.

A county does not have implied power to purchase realty for housing relief clients in individual housing units, although under certain circumstances (no other adequate method of performing its relief duties) it may do so. It may use property acquired through tax title for such purpose. 28 Atty. Gen. 372.

7. Authorizing Relief

(a) Prior Authorization Necessary

Anyone furnishing supplies or services to the poor must be authorized by the proper relief officials prior to furnishing the supplies or services, in order to be able to enforce payment therefor. *This is true even in an emergency*, except hospitalization in the instance explained under "Emergency Relief."

Jones v. Town of Lind, 79 Wis. 64, 67: "As the town can only be chargeable for the services rendered by virtue of some contract made with its officers for such services, we think the circuit court was clearly justified in reversing the judgment * * *."

Patrick v. Town of Baldwin, 109 Wis. 342, 353: "The agents empowered to act for the municipality in such matters must, either by express contract or by some act or acts from which a contract can be

reasonably inferred, bind such municipality, or it cannot be bound at all."

Menasha Woodenware Co. v. Winter, 159 Wis. 437, 454: "A town has no authority to pay the debts of poor persons. It is chargeable with the duty of presently caring for and aiding them when in need, but it has no power to pay their past debts or debts not lawfully incurred on the credit of the town."

The board or council may, however, voluntarily pay for relief furnished in reliance on the credit of the town, although not authorized by one actually having power to authorize it. This may be done on the theory of ratification of the unauthorized contracts of an agent. For example, a health officer's act in authorizing dental work for a poor person.

MacLeod v. Washburn, 178 Wis. 379, where ratification of a mayor's employment of an attorney was upheld, although the mayor had no power to make the employment.

Koch v. Milwaukee, 89 Wis. 220, 228, where it was said: "A municipal corporation may ratify the unauthorized acts and contracts of its agents which are within the scope of its corporate powers, and such ratification is equivalent to previous authority."

See also Frederick v. Douglas County, 96 Wis. 411, 424.

It would even seem that the acts of one who is not an agent for the municipality might be adopted and ratified, provided the relief was furnished for and on behalf of the municipality. In the Menasha Woodenware Co. v. Winter case, supra, the court refused to permit the payment of past debts of a poor person "not lawfully incurred on the credit of the town," but did allow a storekeeper's account to be paid for goods furnished in excess of what the poor authorities had previously authorized. The court said, page 453: "The town board * * * could have allowed a larger amount in the first instance. A larger amount was furnished. They could ratify what they might have done originally. There is no showing that more than what was reasonably necessary was furnished. The goods were sold with the understanding that the town would pay for them, and credit was given the town."

See also 21 Atty. Gen. 149; 21 Atty. Gen. 1067.

Also St. Joseph's Hospital v. Withee, 209 Wis. 424–425: "The law, as pointed out in Patrick v. Baldwin, 109 Wis. 342, 85 N. W. 274, does not permit a private party, at the expense of the town, to aid or relieve an indigent person without a contract to that effect existing between him and the town."

Emergency ambulance service must be previously authorized. 24 Atty. Gen. 332.

(b) Who May Authorize Relief

Sec. 49.01 provides that "The town board, village, trustees, or common council * * * shall have the oversight and care of all such poor persons * * * and shall see that they are properly relieved and taken care of * * *."

In Patrick v. Town of Baldwin, 109 Wis. 342, 353, it was said: "The statute, as has been said, does not indicate that the supervisors must act in a body in contracting for the relief of a poor person. The nature of the duty in such cases is not consistent with such a requirement. The statute must have a reasonable, sensible construction, in view of the duty imposed. It says that 'the supervisors' shall see that poor persons are taken care of as required by law. That clearly indicates that at least a majority must consent to relief being furnished to a pauper at the expense of their town in order to bind it."

(c) Amount of Relief Authorized

The authority from the board, or, in emergency cases, from the town chairman, village president, etc., should be specific as to the amount of relief.

For example, if a doctor is authorized to make but a single call, and the patient requires further calls, the doctor must secure authority to make such additional calls. Or, if he is authorized to treat the patient for measles and finds an appendectomy necessary, authority for the latter must be secured.

Even in emergency cases, prior authority must be secured, except hospitalization as explained under "Emergency Relief."

Of course, authority may be in general terms, such as to "do whatever is required." The extent of authority is always a question of fact.

(d) Standardizing Authorization

Inasmuch as medical aid may be granted through the authorities having charge of aid to dependent children, old-age pension, etc., as well as by those directly in charge of ordinary poor relief, the securing of authorization is not always simple. However, in practically all counties, the relief agencies and the physicians have cooperated in some plan to simplify the rendering of medical service. In some, a schedule of fees has been established; in others, contracts have been made between relief agencies and medical societies, etc. As a result of this cooperation, there is a growing tendency for the particular agency which asks for medical service to undertake to secure any necessary authorization, both for the service and as to the amount of service. The State Department of Public Welfare strongly recommends that there be a definite plan of authorization, to the end that both patient and physician may avoid the need of contacting more than one relief agency; and the Department has prepared suggested forms for use in medical referral. *(Medical Care for Recipients of The Social Security Aids in Wisconsin—1939.)*

8. Emergency Relief and Hospitalization

Subsec. (1) of Sec. 49.18 provides that, unless the board or council shall have designated some other official therefor, the town chairman, village president, mayor, or chairman of the county board, shall provide temporary medical relief.

Subsec. (2) (enacted in 1933) makes an exception to the hard and fast rule requiring previous authorization. It provides that the town, city, village

or county shall be liable for hospitalization in instances where a physician reasonably finds that immediate hospitalization is required, for indispensable emergency operation or treatment "and prior authorization for such hospitalization cannot be obtained without delay likely to be injurious to the patient."

The physician's services and compensation are not included under subsec. (2); he must still receive prior authorization if the public is to be charged.

In order to make the public liable for hospitalization, written notice must be mailed or delivered to the official designated in subsec. (1) within twenty-four hours after admission of the patient, reciting the name and address of the patient, so far as known, and the nature of the illness or injury and the probable duration of hospitalization. Inasmuch as the hospital is most interested, it should exercise diligence as to the notice.

An amendment of the law in 1935 permits the municipality paying for such relief to recover from the municipality of *legal residence*. (Chap. 453, Laws of 1935.)

Misc. op.: 23 Atty. Gen. 847; 26 Atty. Gen. 239; 28 Atty. Gen. 16.

9. What Should a Physician Do When Called to Treat a Person Who is Obviously Indigent But for Whom the Poor Authorities Refuse to Grant Relief?

Inasmuch as the municipality is required, by statute, to relieve poor persons, the doctor should notify the proper authorities that the person requires aid. If they fail to render the aid "they are doubtless amenable in some way for such misconduct." Patrick v. Town of Baldwin, 109 Wis. 342, 354. A writ of mandamus will lie to compel a county board of supervisors to perform its duties. State ex rel. Owen v. Stevenson, 164 Wis. 569. The writ should be sued out by the person requiring relief, as being the person in interest, and not by the doctor. State ex rel. Board of Education v. Haben, 22 Wis. 660; State ex rel. Milwaukee County v. Buech, 171 Wis. 474.

Poor relief officials are criminally liable and liable in damages for wilful failure to care for needy persons. 21 Atty. Gen. 1141.

If the doctor were to render aid in such a case, it would seem that something must transpire between him and the poor authorities upon which an implied contract for his services can be predicated, in order that the town can be held liable.

Under authority of Davis v. Town of Scott, 59 Wis. 604, it might seem that the doctor could continue to render services, after notice to and failure of the poor authorities to perform their duties in such an instance. It was said in the Davis case, at p. 608: "Nor is the primary duty and liability of the defendant town any the less stringent and absolute by reason of the town of Clayton being ultimately liable. We do not think the town is liable until notice is brought home to the supervisors, or some of them. Assuming that such notice was given, and that the woman and her children were in a condition to be a proper town charge * * * then the defendant is liable to the plaintiff for just compensation for whatever time he supported such paupers after such notice, and for which he has received no compensation."

In Beach v. Town of Neenah, 90 Wis. 623, 625, the Davis case was cited as an instance of implied contract.

Patrick v. Town of Baldwin, 109 Wis. 342 discusses the Davis case, not with reference to the holding, but with reference to the notice necessary to the town ultimately liable. However, in the Patrick case it is later said, p. 354: "Performance of that duty by the person designated by law is absolutely essential to create a binding obligation upon the municipality to compensate one for relieving a poor person, legally entitled to relief at its expense * * * Mere neglect of the supervisors of a town to act when they ought to act for the relief of a poor person, would [not] give a private party, not liable by law to furnish such relief, and residing in such town, the right to do so at the expense thereof. There is no more reason for holding that a person may aid a pauper, upon the supervisors of the town in which such pauper has a legal settlement neglecting their duty, and hold such town liable therefor, than for holding that one may repair the highways of a town because its supervisors neglect their duty in that respect, and recover of such town therefor."

In St. Joseph's Hospital v. Town of Withee, 209 Wis. 424–425, the court said: "The law, as pointed out in Patrick v. Baldwin, 109 Wis. 342, 85 N. W. 374, does not permit a private party at the expense of the town to aid or relieve an indigent person without a contract to that effect existing between him and the town. The officers * * * terminated the arrangement theretofore existing between the town and the hospital under which the town was liable for the maintenance. This termination occurred March 26, 1931. The services rendered thereafter * * * were not so rendered under any contract or promise to pay therefor on the part of the town. This leaves the respondent [hospital] without remedy against the town for the services rendered after that date."

The foregoing deals with the right of the physician to *compel* payment for services not previously authorized. With reference to the right of the municipality to voluntarily pay for unauthorized relief, see remarks under "How relief is authorized."

While there appears to be no legal barrier to prevent the doctor from withdrawing from the case, in such a situation, at least after giving notice to the authorities, yet a principle of medical ethics is involved, and the physician's conduct is a matter that he must decide for himself. Clearly, even the most ethical and tender-hearted physician must somewhere draw the line.

10. Obstetrical Cases

There is no difference between obstetrical cases and other medical care, insofar as the liability of the public is concerned. Prior authority to handle the case must be secured, as in other cases.

11. Habitual Drunkards and Drug Addicts

Wisconsin Keeley Institute Co. v. Milwaukee County, 95 Wis. 153, holds that a municipality is not required to furnish an habitual drunkard with care in a private institution for the cure of such affliction.

Note, however, that drunkenness and use of drugs are reasons why a person may be committed to a county home, or an asylum. Secs. 49.07, 51.26 (5), 51.26 (6). 25 Atty. Gen. 288.

12. Hospitalization, Nurse, Etc.

A doctor authorized merely to treat a sick poor person may not, without prior authority, order the patient to a hospital, or employ a nurse, at public expense, except as set forth in "Emergency Relief."

13. Quarantine

Sec. 143.05 (10) provides the procedure for indigent transient quarantine cases. There should be no conflict between the administration of that section and Sec. 49.03 (9). See 27 Atty. Gen. 532.

Sec. 143.05 (10) provides that expenses for necessary nurses, medical attention, food and other articles needed for the comfort of the afflicted person shall be cared for at municipal expense.

Sec. 143.03 (2) provides that: "Local boards of health may do what is reasonable and necessary for the prevention and suppression of disease; may forbid public gatherings when deemed necessary to control epidemics, and under direction of the state board, shall furnish antitoxin free to indigent persons suffering from communicable disease." See 21 Atty. Gen. 303; 22 Atty. Gen. 894; 25 Atty. Gen. 514.

14. Medical Care in Jails, Etc.

The sheriff is required by statute to furnish medical care to prisoners. Sec. 55.07 (3). This is not poor relief, but must be furnished whether or not the prisoner be poor; it is furnished to him just as are his food and bedding. The statute contemplates payment by the sheriff and reimbursement of him by the county. See Deissner v. Waukesha County, 95 Wis. 588; Hartwell v. Supervisors, 43 Wis. 311; Bell v. Fond du Lac County, 53 Wis. 433. However, the county is responsible for the medical care of prisoners. See Rider v. Ashland County, 87 Wis. 160, 163, where it was said: "It is no doubt, the duty of the county board to procure and furnish all needful medical aid and attendance to persons confined in its jail." It would therefore seem that recovery might be had direct from the county, at least if the sheriff failed to pay.

The sheriff is not required to furnish outside hospitalization. When a prisoner requires hospital care, and is entitled to poor relief, such hospitalization must be authorized and furnished by the poor relief authorities. 20 Atty. Gen. 374–375, 436–437. The sheriff as such has no authority to incur expense under the poor relief laws. Hittner v. Outagamie County, 126 Wis. 430. 28 Atty. Gen. 16.

15. Poor Relief by Relatives. Sec. 49.11

The father, mother, husband, wife, or children of any poor person who is blind, old, lame, impotent, or decrepit or for any other reason is unable to maintain himself, may be compelled to relieve and maintain such person.

The statute fixes the order of liability, as follows: First the husband or wife; then the father, then the children; and lastly the mother.

The poor authorities may secure an order of the county court compelling relief. The court, in making the order for relief, shall take into consideration the financial status of the person compelled to furnish the relief, "having due regard for their own future maintenance and making reasonable allowance for the protection of the property and investments from which they derive their living and their care and protection in old age."

The court may order partial maintenance, when the relative chargeable cannot wholly support but can contribute; or the court may order two or more relatives to share the burden.

The liability of a child to support its parent is wholly statutory, and the statutory provisions for enforcing such support must be followed. County court therefore has no power to order support paid from estate of an incompetent. Guardianship of Heck, 225 Wis. 636.

Grandparents cannot be compelled to support grandchildren. 5 Atty. Gen. 100.

Brothers and sisters not liable for support. 27 Atty. Gen. 847.

A wife having no separate estate and no property except her inchoate dower and homestead rights is under no legal obligation to support her indigent parents. Her husband is under no legal obligation to contribute to the support of her parents. 8 Atty. Gen. 29.

16. Proof of Indigency

When the poor authorities have authorized a physician to treat a supposedly poor person, the burden of proof is not upon the physician to prove the person was entitled to aid, in order to collect his fee. In Elkey v. Seymour, 169 Wis. 223, 228, it was said: "While it was incumbent upon the plaintiff, dealing with public officials, to know or ascertain at her peril the scope of the powers of such public officials, she was not required to examine further and to ascertain whether or not the person to whom such lawful authorities proposed to grant relief, * * * did not meet the calls of the statute

which prescribed the duties and obligations of such authorities in the care of the poor. *That duty rested upon such officers.*" (Italics ours.)

17. Cutting Physician's Bill

When the town, county, or village board, or city council, "allows" a physician's bill at less than the amount thereof, what may the physician do?

He may accept such lesser amount and may sue for the balance. Secs. 59.76, 62.25, 60.35 (1), and 61.51, and Sharp v. Mauston, 92 Wis. 629.

From a practical standpoint, it is advisable that the doctor's fee, or at least rate of charge, be specified at the time of being authorized to render the services.

18. Must Physician's Bill Be Itemized?

A physician's bill must be itemized, and sworn to. See Secs. 59.77, 62.12 (8), 60.33 (2), and 61.51.

19. Is Doctor's Pay Dependent Upon Results?

In Ladd v. Witte, 116 Wis. 35, 39, the supreme court criticized an instruction to the jury: "It certainly tended to confine the jury to consideration of *what and how much benefit resulted* to the defendant from this fruitless incision into the body of his new-born child, whose death was certain without the operation, but equally occurred, it notwithstanding. *That is not at all the test.* So that a surgical operation be conceived and performed with due skill and care, the price to be paid therefor *does not depend on the result.* The event so generally lies with the forces of nature that all intelligent men know and understand that the surgeon is not responsible therefor. In absence of express agreement, the surgeon who brings to such a service due skill and care earns the *reasonable and customary price* therefor, whether the outcome be beneficial to the patient or the reverse." (Italics ours.)

In Holsapple v. Scofield, 176 Wis. 649, 651, it was said: "If the plaintiff performed the dental service for the defendant and did the same in good, workmanlike manner in accordance with the recognized and established practice of those in the same profession in his locality, he became entitled to the reasonable value of his services."

In Wurdemann v. Barnes, 92 Wis. 206, 207, an action by a physician to recover his fees, the court said: "There was no claim that the charges were above the usual rate for such services, and therefore there was no question for the jury."

And on page 208 it was said: "It is claimed that the defendant's son grew worse under the plaintiff's treatment, and that he grew better after the plaintiff had been discharged, but this does not show that the plaintiff was guilty of negligence or unskilfulness in treating him. * * * He could not be held responsible simply because he failed to cure the defendant's son, nor for mere misjudgment in treating him, if the treatment was such as physicians and surgeons of ordinary knowledge and skill would apply."

20. Malpractice

Relief units are not liable for malpractice of physicians who are paid by such units. 23 Atty. Gen. 829. A physician is not relieved of liability for malpractice merely because he is engaged in a semi-governmental function. 21 Atty. Gen. 927; 23 Atty. Gen. 829.

21. Commitment to County Home

Commitment is by order of the judge of any court of record, on petition of the official in charge of the poor, if there be but one, or by any two officers in charge of the poor, of any town, city or village, or county.

Any person having legal settlement who is without sufficient means of support and is by reason of sickness, infirmity, decrepitude, old age, drunkenness, addiction to drugs, or pregnancy likely to become a public charge, either temporarily or permanently, or who lives in a state of indigence, squalor or filth likely to induce disease, or who has moved to another municipality and received temporary aid there (at the expense of the municipality of settlement, of course), may be committed to the county home. Sec. 49.07.

If the county has no county home, the person may be sent to the county home of another county, but not without first having opportunity to be heard.

Where person is committed to county home, county cannot make a contract for support of such person in a private home. 26 Atty. Gen. 483.

Inebriates or drug addicts may be transferred to a county or state insane asylum after hearing before the county judge. Sec. 51.26 (5).

22. County Hospital and County Insane Asylum

A county may establish a county hospital, for the treatment of indigents and persons afflicted with any disease, malady, deformity or ailment, which can probably be remedied or treated advantageously, who are financially unable to provide for their own treatment.

Persons not indigent may be received and treated at actual cost. Sec. 49.145.

Counties may maintain county insane asylums. Sec. 51.25. Commitment may be by the county judge (sec. 51.05), and, in case of insane paupers, by the county judge on petition of a majority of the supervisors of any town, of the common council of any city or of the board of trustees of any village (sec. 51.09). Admission may also be upon voluntary application of the person, supported by certificate of two physicians. (Sec. 51.10.)

Inebriates or drug addicts may be committed to such asylum after hearing before the judge of any court of record. Sec. 51.26 (6).

The county of legal settlement is liable for the cost. Secs. 51.10 and 46.10. If the inmate has no settlement, the state is chargeable. Sec. 46.10. 25 Atty. Gen. 288.

23. County Tuberculosis Hospital

Such a hospital may be established by any county. Sec. 46.17. Admission may be had by any person suffering from tuberculosis or showing symptoms thereof, on presentation of a certificate of a physician so stating and upon approval of the county judge of the county of residence. Sec. 50.07.

Indigents are cared for at the expense of the county of settlement, with state aid. Sec. 50.07. 21 Atty. Gen. 119.

24. Soldiers and Sailors Relief

Section 45.10 makes it the duty of the county board to levy annually a tax sufficient to provide relief to needy soldiers, sailors, and marines, and for indigent wives, widows, and dependent children of such persons. It is mandatory that the county board reasonably estimate the needs and levy the tax accordingly. 21 Atty. Gen. 960. The county board must make a reasonable not arbitrary estimate. 29 Atty. Gen. 240.

This special provision for needy veterans does not relieve the town or county from the obligation to relieve them, except insofar as their need is removed by this special relief. 21 Atty. Gen. 522, 719.

The relief is limited to the tax levied, and so the county board may not in any year make further appropriation to the soldiers' relief commission. 21 Atty. Gen. 719. But where the budget upon which the county levy is made contains a specific contingent fund, deficiency in the soldiers' relief fund may be met therefrom. 21 Atty. Gen. 960.

Relief is limited to those who served in time of war. 24 Atty. Gen. 101.

A widow is not entitled to relief after remarriage. 24 Atty. Gen. 47.

Misc. op.: 24 Atty. Gen. 54, 238; 25 Atty. Gen. 587; 27 Atty. Gen. 276. 29 Atty. Gen. 71.

25. Hospitalization of Soldiers and Sailors

Sec. 45.275 requires the soldiers' rehabilitation board to provide hospitalization for any indigent, disabled, honorably discharged soldier, sailor, marine or nurse of any war who is ineligible to hospitalization under federal law. The applicant must have been a resident of Wisconsin for five years prior to application. Treatment shall be at the Wisconsin General Hospital except in emergency cases or those requiring special treatment which can only be provided elsewhere.

By provision of Secs. 142.09 and 142.10, preference in order of admittance to Wisconsin General Hospital shall be given honorably discharged veterans of any of the wars of the United States. Any such veteran may be permitted to enter the Wisconsin General Hospital and obtain all care including professional service at the clinic cost rate. The veteran must have been a resident of this state for not less than five years next preceding his application for treatment. See Title 27, this digest.

26. State Tuberculosis Hospitals

Such hospitals are maintained by the state. Sec. 50.01.

The state board of health appoints physicians throughout the state for the examination of applicants, whose reports are forwarded to the hospital superintendent. On notice from the superintendent, the patient is admitted. The physician receives a fee of $4.00 for making the examination, which is paid, in the case of indigents, by the state, one-half being charged back to the county of settlement. Secs. 50.02 (2), 50.03. Admission is upon approval of the county judge of the county of residence. Sec. 50.02 (1). Half the cost is charged to the county of settlement. Sec. 50.03.

27. Wisconsin State General Hospital

This hospital is maintained by the state at Madison. Commitment is by application to the county judge, made by any sheriff, county supervisor, town clerk, health officer, health nurse, poor commissioner, policeman, physican, or any public official, all of whom *shall* make application if the need come to attention, or by any teacher, priest or minister, who *may* make application. The county judge makes investigation of the financial and physical condition, appoints a physician to examine the person, and makes a finding that the person may be advantageously treated at the hospital or rehabilitation camp (sec. 142.01) and then makes an order sending him there. If the person or his guardian makes selection of that hospital, the person shall be sent there. Secs. 142.02, 142.03.

If the county judge finds that the person can be treated as advantageously at home or in another hospital, and if the person or his guardian does not make selection of the state hospital, and if the judge finds that the cost of treatment at home or in another hospital will be the same or less than the cost to the county for having the person treated at the state hospital, the judge shall make order for such treatment at home or at another hospital, the order to specify the place of treatment and the physician. Sec. 142.04.

In determining the cost to the county, the judge should take into consideration the traveling expense of the person, as well as of the guardian or other person who may necessarily accompany the person, both to and from the hospital, keeping in mind that all of such traveling expenses are borne by the county without state aid. 20 Atty. Gen. 933.

In 22 Atty. Gen. 463, at 465, the Attorney General said: "It is our opinion, therefore, that the county judge, in an emergency, may make a commitment to a nearby hospital even where the expense would be somewhat more than the cost of treatment at Madison." In arriving at that conclusion, the Attorney General said: "The provisions of Chapter 142 are intended to be beneficent in their nature and should be liberally construed to effectuate the evident intent back of their enactment. * * * It is not

only a charitable statute but one that is humane as well. It is not believed that the legislature intended to endanger the life of an indigent by insisting upon his removal to Madison where the treatment would be slightly less costly if the patient were able to survive the trip. * * * Where the trip to Madison would necessarily endanger the life of the patient and probably very materially impair his chances of surviving the treatment even if the trip itself were endured, it is not believed that the treatment at Madison would be considered adequate or that the county judge would be bound to prescribe treatment, if any, at Madison." See also 22 Atty. Gen. 875.

The cost of treatment at home or in local hospital must be paid by the county treasurer upon certificate of the county judge who shall be satisfied as to the correctness and reasonableness thereof. 21 Atty. Gen. 240; 24 Atty. Gen. 202. Sec. 142.08 (5).

The number of patients certified to the Wisconsin General Hospital, at joint county and state expense, in any one fiscal year is limited to two persons per thousand of population or major fraction thereof in the county according to the last federal census; and patients certified in excess of such number shall be maintained wholly at county expense. The limitation does not apply to patients certified to the Wisconsin Orthopedic Hospital nor to counties in which there is no hospital. Sec. 142.04. See 24 Atty. Gen. 155.

Commitment must be from county of legal settlement. 21 Atty. Gen. 846. One who does not have legal settlement within the county as provided for by Sec. 49.02, although he may have resided in county a year or more, may not petition the court for hospitalization. 27 Atty. Gen. 708.

The physician who examines the patient must make written report to the judge. The selection of the examining physician rests in the discretion of the judge. Prior to 1927, the examining physician was required to be one residing in the county. The law was amended in that year, however, by striking out that requirement, the purpose of the amendment being, as explained to the legislature, to facilitate the examination of patients residing near county lines. Sec. 142.03.

The examining physician is paid five dollars, by the county, for making examination. Sec. 142.03. His appointment by the judge is a question of fact, and if he receives authentic knowledge of his appointment, he may proceed to make the examination, without waiting for a formal, written appointment. Obviously, he could receive authentic knowledge of his appointment orally from the court, as by telephone.

A contract cannot be made by the county with a county medical society which will take away the judge's discretion as to place of hospitalization. 23 Atty. Gen. 711.

County judge may authorize furnishing glasses under Chapter 142. 25 Atty. Gen. 429.

Nurse transporting patient at request of county court may be held liable for negligence in accident occurring during such transportation. Liability insurance may not protect nurses if mileage paid for transporting patient is construed as transportation for hire within terms of most liability insurance contracts. County would not be liable, as it is acting in performance of essential governmental function. 27 Atty. Gen. 339.

Misc. op.: 22 Atty. Gen. 1051; 23 Atty. Gen. 439; 24 Atty. Gen. 384; 27 Atty. Gen. 143.

28. Crippled Children

(a) Orthopedic Hospital

The state maintains the children's orthopedic hospital at Madison, for the treatment of crippled children whose parents are unable to provide adequate treatment.

Half the cost of treatment is charged to the county. Sec. 36.32.

The method of commitment is the same as for commitment to the Wisconsin General Hospital. Sec. 36.32 (4) and Sec. 142.04. Report to and cooperation with the bureau for the handicapped children of the department of public instruction is required. Sec. 142.03 (1).

(b) State Public School at Sparta

Crippled or deformed children may be admitted to the state public school, if their ailment or deformity is subject to cure or amelioration. Sec. 48.21.

Insane, feebleminded or epileptic persons are not admitted. Sec. 48.20.

Admission to the school is through the department of public welfare. Sec. 48.20.

One-half the cost is charged to the county of the child's legal settlement. Sec. 48.20. The expense of a person to accompany the child is charged to the county.

(c) Special District Schools

School districts may maintain special schools for crippled children. Sec. 41.01.

By chapter 231, Laws of 1939, the laws relating to education of crippled children were extended and strengthened. State aid for special schools for such children was set up, a bureau for handicapped children was established in the department of public instruction, schooling was made compulsory, etc.

(d) Interdepartmental Committee and Federal Aids

In 1935 section 48.50 of the statutes was enacted, constituting an interdepartmental committee consisting of the superintendent of Wisconsin Orthopedic Hospital, state health officer, and director of the children division of the state department of public instruction. The duty of the committee is to prepare a unified and comprehensive plan for services for crippled children—locating them, furnishing medical, surgical, corrective and other care, and facilities for

diagnosis, hospitalization, and aftercare. The committee's plan is to take into consideration federal aids and services.

See 24 Atty. Gen. 812.

29. Dependent and Neglected Children

(See also "Mother's Pension." Title 31 (d), this digest.)

Such children may be sent to the state public school at Sparta.

Admission is by department of public welfare. Sec. 48.20.

Such children may also be sent to any other suitable public institution or placed in the care of relatives or a child welfare agency. Sec. 48.07.

Misc. op.: 20 Atty. Gen. 1246; 21 Atty. Gen. 267; 22 Atty. Gen. 312; 24 Atty. Gen. 133, 195; 25 Atty. Gen. 574, 577.

30. Education of Blind and Deaf

(See also "Blind Pension." Title 31 (f), this digest.)

Schools, workshop and employment agency are maintained by the state. Secs. 47.01, 47.02, 47.05.

No tuition is charged. Sec. 47.02.

Admission is on order of the county or municipal judge. Sec. 47.03.

Admission is also voluntary. Sec. 47.02.

The state bears entire expense.

Legal settlement is not essential for admission. 24 Atty. Gen. 512.

31. Pensions

(a) State Pension Department. Sec. 49.50

The State Pension Department shall "supervise the administration of old-age assistance, aid to dependent children, and blind pensions."

To enable the state to receive federal aid, the department is given authority to make rules and regulations, and county officers and employes are required to conform thereto. By Chap. 435, Laws, 1939, the functions of the State Pension Department were transferred to the State Department of Public Welfare, Division of Public Assistance.

(b) County Pension Department. Sec. 49.51

A county may establish a county pension department, in which case such department is charged with administering the forms of relief mentioned above.

Misc. op.: 24 Atty. Gen. 698, 709, 710, 711, 763, 764, 765.

(c) Applications

Application for either form of relief is made to the county judge (or to the county pension department if one has been established), who makes proper investigation and fixes the amount of pension. Secs. 49.28 (old-age assistance), 48.33 (aid to dependent children), 47.08 (blind pension).

A denial of pension may be appealed to the State Department of Public Welfare, and its decision shall be final. Sec. 49.50 (4).

(d) Aid to Dependent Children. Sec. 48.33

This is the form of relief commonly but erroneously known as "Mother's Pension." It is not necessarily given to the mother, but is given to the person having the care and custody of one or more children under the age of sixteen and dependent upon the public for proper support. Aid may be given, in the court's discretion, for minor children over the age of sixteen, but no federal aid is given the county for such cases. Subsec. (5) (a).

Application must be made in the county of legal settlement, but the children may, with the approval of the court, reside outside the county. Subsec. (5) (b).

Aid is granted to a mother if without a husband, or the wife of a husband who is incapacitated for gainful work by mental or physical disability likely to continue for one year, or the wife of a husband sentenced to a penal institution for at least a year, or the wife of a husband who has deserted her for one or more years if the husband has been legally charged with abandonment, or to a wife who is divorced and for one year has been unable to compel her former husband to support the child. Subsec. (5) (d). 26 Atty. Gen. 289, 304, 490.

Dependent children of veterans must be eligible under sec. 48.33 (5) as subsec. (13) added by Chapter 200, Laws of 1939, provides only for determination of county liability for children of veterans who are in institutions outside their home counties. Atty. Gen. opinion Oct. 23, 1940.

The amount of aid to dependent children shall be "sufficient to enable the person having the care and custody of such children to care properly for the children. The amount to be granted shall be determined by a budget for each family in which all possible income as well as expenses shall be considered." Subsec. (6). Note that the budget is for the "family," not merely for the needs of the children.

In an unofficial opinion by the Attorney General to the State Pension Department, dated July 11, 1939, it was held that medical and dental aid may be granted to an incapacitated father, whether or not he is the supervising adult within the meaning of section 48.33 (7) of the statutes. The pension agency is given discretion as to such aid but may not abuse the discretion.

The ownership of a homestead by the person having the care of the children shall not bar aid if the total cost of maintenance of the homestead does not exceed the rental which the family would be obliged to pay for living quarters. Subsec. (5) (f).

Maternity aid, in the form of supplies, nursing, medical or other assistance, shall be granted during the period from six months before to six months after the birth of a child. Sec. 48.331. 27 Atty. Gen. 256, 258.

Aid to dependent children does not prevent nor relieve the relief unit from furnishing medical aid. Sec. 48.33 (6) provides: "Medical and dental aid

may be granted to minor children, the mother or the incapacitated father, as necessary." Also: "Aid pursuant to this section shall be the only form of public assistance granted to the family for the benefit of of such child, *except medical* and dental aid." See 20 Atty. Gen. 146; 21 Atty. Gen. 952.

Directly in point with the foregoing statement is the holding in Town of Cleveland v. Industrial Commission, (Wis.), 286 N. W. 558, where the court said: "* * * the provision in subd. (6) of sec. 48.33, Stats. (above quoted) that such aid for dependent children 'shall be the only form of public assistance granted to the family', etc., *cannot be construed to prohibit and render illegal the performance of the statutory duties prescribed by sec. 49.03 (1), Stats.* The scope and effect of whatever inhibition there is by reason of the above quoted provision in subd. (6) of sec. 48.33, Stats., *is limited to the action on the part of officers engaged in the granting of aid for dependent children* * * *" (Italics ours.)

Also the case must be construed as meaning that the language "except medical and dental aid" as used in sec. 48.33 gives express authority for those who administer aid to dependent children to provide medical and dental aid.

The acceptance of aid under a federal rehabilitation program does not necessarily disqualify for aid under section 48.33. 24 Atty. Gen. 522; 26 Atty. Gen. 610.

Misc. op.: 22 Atty. Gen. 769, 772, 920, 952, 1002, 1041; 23 Atty. Gen. 452; 24 Atty. Gen. 26, 158; 25 Atty. Gen. 68, 470, 505; 26 Atty. Gen. 133, 180.

(e) Old-Age Assistance

The applicant must have attained the age of 65 years, but aid can be given at age 60 when the federal government grants assistance for ages 60 to 65. Sec. 49.22 (1).

Applicant must have been born in or be a citizen of the United States. He must have resided in Wisconsin at least five years during the nine years immediately preceding application, during the last year of which period he must have resided continuously in this state. However, an applicant who has resided one year in the state of Wisconsin may be granted old-age assistance if the state from which he has removed to Wisconsin has undertaken to grant assistance to any resident of Wisconsin who has moved to such state and has lived there continuously for one year. Sec. 49.22 (2), (3). Absence from the state in the service of the state or of the United States shall not be deemed to interrupt residence if a domicile be not acquired outside the state. 25 Atty. Gen. 736.

Applicant must not be an inmate of any prison, jail, workhouse, infirmary, insane asylum, or any other public correctional institution. Sec. 49.22 (4).

He must not have a child or other person responsible for his support and able to support him. Sec. 49.22 (8). 26 Atty. Gen. 382.

Persons may not be granted old-age assistance while inmates of and receiving the necessities of life from any public institution, or while an inmate of a private charitable, benevolent or fraternal institution or home for the aged to which no admission charge as a life tenant has been made. An inmate of a county home may make application, but assistance shall not begin until he ceases to be such inmate. A person shall not receive assistance if the combined property of husband and wife living together exceeds five thousand dollars; or who has deprived himself of any property for the purpose of qualifying for assistance. Sec. 49.23. 28 Atty. Gen. 234.

The amount of assistance shall not exceed an amount which, when added to the other income of the applicant, shall exceed a total of forty dollars per month. Sec. 49.21 as amended by chapter 533, Laws of 1939. 26 Atty. Gen. 306.

Subsec. (4) of Sec. 49.26, as created by chapter 7, Laws of Special Session 1937, provides that when a certificate of old age assistance is filed in the office of the register of deeds it operates as an automatic statutory lien against the real estate of a beneficiary which is situated in the county where filed. The county pension authority may still require the transfer of realty situated without the State of Wisconsin or of personalty with the exception of an insurance policy of less than one thousand dollars in value. Sec. 49.25 providing for claims against the estates of old age assistance beneficiaries was also amended by chap. 7, Laws of Special Session 1937, and this amendment should be consulted. Priority of old age assistance claims and liens in probate are discussed with relation to fact situations, 27 Op. Atty. Gen. 751. In checking the following opinions they should be read with reference to the time of change in the law. 26 Atty. Gen. 322, 418, 564; 27 Atty. Gen. 69, 751, 830.

Funeral expenses not exceeding one hundred dollars may be allowed. Sec. 49.30. Subject to the limitation that discretion granted to an administrative officer may never be arbitrarily exercised, the director of old-age assistance within the limitations imposed by sec. 49.30, Stats., controls both who shall act as undertaker and the amount to be paid for such services. 29 Atty. Gen. 346.

During the continuance of old-age assistance, no recipient shall receive any other relief from the state or any political subdivision "except for medical and surgical assistance." Sec. 49.31. If the assistance granted is not adequate for the medical or surgical needs, then medical and surgical relief shall be extended through the regular relief channels. 25 Atty. Gen. 287; 26 Atty. Gen. 306.

State and federal aid is given counties. Secs. 49.38, 49.51, 20.18 (6), 20.748.

The county board may require each town, city and village to reimburse the county for all amounts paid in old-age assistance to its residents, less state and federal aid. Sec. 49.37 (2).

An Indian on a reservation may receive old-age assistance. 24 Atty. Gen. 591.

Old-age assistance is exempt from garnishment, levy, etc. Sec. 49.32

Misc. op.: 23 Atty. Gen. 820; 24 Atty. Gen. 280, 438, 624. Income defined and property discussed, 24 Atty. Gen. 461, 709, 710, 711, 763, 764; 25 Atty. Gen. 115, 250; 26 Atty. Gen. 206, 218, 526, 576.

Eligibility to pension offices see: 24 Atty. Gen. 698, 762, 765, 768, 771; 25 Atty. Gen. 55; 26 Atty. Gen. 52; 28 Atty. Gen. 353.

(f) Blind, and Blind-and-Deaf Pension

Any needy blind or blind and deaf person eighteen years of age or more shall receive pension. Sec. 47.08 (1).

It shall be in an amount which, when added to income from other sources, shall not exceed $780 per year. But no pension shall exceed $360 if the person is blind and $480 if both blind and deaf. Sec. 47.08 (1).

Residence requirements are the same as for old-age assistance, except that if an applicant lost his sight while a resident of the state, then he need not comply with the other resident requirements. 27 Atty. Gen. 828.

Applicant must not be an inmate of any publicly-owned charitable, reformatory or penal institution or any public school for the blind or deaf (except summer school of the Wisconsin school for the blind); must not be publicly soliciting alms; must not have relatives legally responsible for his support and able to support him. Sec. 47.08 (2).

All applicants must be examined by a regular practicing physician, appointed by the county board, and designated "Examiner of the Blind and Deaf." Sec. 47.08 (4). Fee paid the physician is $2.00 for each applicant, but the county board may allow a larger fee. 25 Atty. Gen. 671.

A person is not entitled to blind pension while receiving old-age assistance. Sec. 47.08 (8).

Husband and wife may each receive pension. 24 Atty. Gen. 445.

Recovery from estate of blind pensioner is not permissible. 27 Atty. Gen. 141.

(g) Miscellaneous

The State Department of Public Welfare policy is to include in the grant to old-age and blind pensioners the amount necessary for medical aid (within the statutory limits as to amount of pension, of course), leaving it to the pensioner to make payment to the physician. In allowing medical aid to dependent children, however, such aid may either be included in the grant or payment of the physician may be made direct by the authorities.

Misc. op.: 22 Atty. Gen. 710; 23 Atty. Gen. 248; 24 Atty. Gen. 109, 449, 709; 25 Atty. Gen. 272, 441, 671; 27 Atty. Gen. 828; 28 Atty. Gen. 360, 499.

32. Offenses

A person may be punished who:

Wilfully makes any false representation with intent to secure relief, for himself or another.

Wilfully does any act designed to interfere with the proper administration of relief.

Sells or exchanges articles or supplies furnished as relief or disposes of them with intent to defraud the relief unit, or who buys the same.

Sends or brings, or advises any dependent to go into, any municipality in order to relieve himself or his municipality from relief.

Being in charge of relief, or any assistant who, receives or solicits any personal financial gain through any purchase, sale, disbursement or contract for supplies or other property used in administering poor relief.

Secs. 49.124, 343.25, 348.28.

Pension frauds are punishable. Secs. 49.34 to 49.36.

Wrong intent is essential. 24 Atty. Gen. 573.

Provisions of Wisconsin General Hospital Law

ACCORDING to the provisions of chapter 142 and section 36.31, Wis. Stats., the State of Wisconsin General Hospital, located in Madison, was established for two primary purposes: (1) to furnish facilities for teaching and the advancement of medical knowledge; and (2) to furnish specialized facilities for the care and hospitalization of patients lacking such facilities within their own communities.

142.01 **Public patients.** (1) A person having a legal settlement in any county in this state who is crippled or ailing and whose condition can probably be remedied or advantageously treated, if he or the person liable for his support is financially unable to provide proper treatment, may be treated at the Wisconsin general hospital or the Wisconsin orthopedic hospital for children at Madison or in such other hospital or rehabilitation camp as the county judge shall direct, except that when the person to be treated, or his guardian if he be under guardianship, shall select that such treatment be at the said Wisconsin general hospital or the said Wisconsin orthopedic hospital or rehabilitation camp, the hospital or rehabilitation camp of his selection shall be the place of treatment; provided that the right of such selection shall not exist in counties having a population of five hundred thousand or more . . .

142.02 **Application.** When the case of such person shall come to the notice of the sheriff, county supervisor, town clerk, health officer, health nurse, poor commissioner, policeman, physician or surgeon, or any public official, he shall and any teacher, priest or minister may, file with the county judge of the county wherein such afflicted person has a legal settlement an application for such treatment at such hospital.

The judge then appoints a physician to investigate the physical condition of the patient. At the same

time the judge makes an investigation as to the propriety of such a commitment, the supervisor of the town, village or ward of residence of the person, shall furnish all information necessary for the judge to pass intelligently upon the case. If the judge is satisfied that the patient or the person liable for his support is financially unable to provide proper treatment and upon recommendation of the physician that the patient is a proper person for hospitalization at the State of Wisconsin General Hospital, the judge shall then issue an order approving such hospitalization, in which instance the cost is borne equally by state and county, provided that the county has not exceeded its quota for that year.

Unless the case is an emergency, the hospital desires the court order certifying the patient to the institution prior to the arrival of the patient. This allows the hospital to delay admission in certain cases where the services are already over-crowded.

Patients are also admitted to the hospital upon receipt of a letter from the family physician stating that the patient can pay $6 a day, in advance, for hospitalization, but that a professional fee or extras in addition would be a severe hardship. A few private cases are also admitted, but the hospital is not primarily interested in this type of work. Address all communications to the office of the Superintendent, 1300 University Avenue, Madison, Wisconsin.

Classification of patients admitted to the hospital, in 1939, is given below:

1. *County-state patient:* Hospitalization is authorized by the county judge of the county in which patient resides. Hospitalization costs are paid equally, half by the county and half by the state unless that county's quota for that year is exhausted in which case the county bears the full burden; (88 to 90 per cent of the patients in the hospital come under this classification).

2. *Special rate patient* (formerly called the "clinic case"): This type of patient comes to the hospital on his physician's recommendation that he be accepted on a $6 per day basis. A financial statement of the patient is taken on admission and if it is felt that his status justifies a $6 per day charge he is admitted on that basis; he is thereby entitled to every service except transfusions and special nursing; (6 to 8 per cent of the patients in the hospital come under this classification).

3. *Private patient:* This type of patient is handled the same as would be the case in any other hospital *except* that he is accepted only on reference or recommendation of the physician in the home community.

No patient is accepted at Wisconsin General Hospital unless referred or recommended by the patient's physician, except in case of emergency or accident where delay may cause serious complications.

Divisions of Wisconsin General Hospital

Wisconsin General Hospital: Admissions per above; general hospital service plus teaching privileges in connection with the University.

Wisconsin Orthopedic Hospital: Orthopedic and plastic surgery patients only. All patients admitted through the regular admitting channels of the Wisconsin General Hospital. Crippled Children's Division secures admission for many patients through its services.

Wisconsin Psychiatric Institute: Furnishes facilities for blood and spinal fluid Wassermann examinations for the various state agencies and institutions, and for any physician desiring its facilities.

Bradley Memorial Hospital: This is a unit of Wisconsin General Hospital.

University of Wisconsin Infirmary: Student health center and hospital.

Scope and Fees

Provisions of the Wisconsin General Hospital Law as it relates to the relief of the medically indigent are contained in other portions of this issue of the Journal*, and the purpose of this article is to treat particularly the extent of the law and the collection of physicians' fees allowed thereunder.

Treatment May Be at Home or in Local Institution

Under the Wisconsin General Hospital Law (sections 142.01 and 142.04) a person having a legal settlement in any county, who is crippled or ailing and whose condition can probably be remedied or treated advantageously, and for whom treatment is financially impossible, may be confined, as the situation warrants, in the Wisconsin General Hospital, in the Wisconsin Orthopedic Hospital, in a local institution or at home.

Conditions Necessary to Local Treatment

Where treatment is to be given at home or in a local institution, the court must find that such treatment will be adequate and at the same or less expense to the county. But it must be kept in mind that the law is beneficent, and must be construed to give effect to its purpose. Thus the Attorney General has held that treatment need not be ordered at Madison in the emergency case, even though the expense might be less than in a local institution, because "it is not believed that the treatment at Madison would be considered adequate. . . ." (XXII Atty. Gen. 465). And in the consideration of "expense," the county judge may take into account the costs necessary to remove a patient to Madison, for transportation expense, and those of an attendant, both to and from the institution, are not items of joint state and county expense.

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* See pp. 1033, 1034, poor relief laws.

The County Quota

Under the provisions of the law, state aid ceases when the total county patients committed from any one county exceeds a ratio of more than two persons per thousand of population or major fraction thereof, although there is no limit if there is no hospital in the county concerned. If the county exceeds its quota, then the county must pay the entire cost of hospitalization if the patient is to be confined in Madison. If the patient is confined at home under the provisions of the law no expense of hospitalization is involved at all. The only expense to the county would be that of medical care and nursing.

Physicians' Fees

In proceedings under the Wisconsin General Hospital Law, two entirely separate and distinct fees are permitted physicians.

By provisions of section 142.03 (2) the county judge, if satisfied that a patient presents a proper situation, "shall appoint a physician personally to examine the person." By statute, the physician is directed to make a verified report in writing giving certain required information, and shall "be paid by the county $5.00 and actual and necessary expenses." Since no method is provided for the payment of the physician, he must proceed through legal channels for the collection of the $5.00 fee allowed. Following the provisions of section 59.77 (1), dealing with claims against the county, the physician must make a statement of his claim in writing upon county voucher forms setting forth its nature and the facts upon which it is founded. If the claim includes mileage, the statement should specify the days and places, so as to show between what points, and when, and the purpose for which the travel charges were made. Since the fee is statutory the time expended in the performance of service need not be stated. But the statement must be verified by affidavit and filed with the county clerk, whose duty it is, under the provisions of section 59.79 to transmit the same to the county board.

A further fee is allowable for medical treatment where a patient may be confined under the Wisconsin General Hospital Law in local hospitals or at home. Where such is the case, the county judge is required to "enter an order directing such treatment, the place thereof, and the physician or physicians." The expense of treatment of such patients, in local institutions or at home, shall be paid by the county treasurer, upon the certificate of the county judge who shall be satisfied as to the correctness and reasonableness thereof. The claim of the physician rendering the treatment need not be passed upon by the county board, but only by the county judge. See sections 142.04 and 142.08 (5). See also XXI Atty. Gen. 240 and XXII Atty. Gen. 408.

Physicians and the Workmen's Compensation Act*

THE workmen's compensation act is designed to afford a measure of protection to the working men of the State of Wisconsin. The law, not applicable to farmers, affects employers who, in the course of a business, trade, profession, or occupation, usually have three or more employes. Benefits are provided an employe sustaining an injury or disease in the course of his employment. It has been stated frequently that all but the employer and the employe are strangers to the act and are unaffected by its provisions. Strictly, this is true. However, when a workman files a claim before the Industrial Commission alleging that he is entitled to benefits under the workmen's compensation act, the commission acquires functions that affect the relationship of the physician and his patient as well as the lawyer and his client.

As has been pointed out previously, many more physicians are constantly coming into contact with the procedures and practices of the Industrial Commission, and because inquiries are frequently directed to the State Medical Society regarding the act and the scope and effect of its provisions, this statement is prepared as a summary of some of the more important aspects of the law. While it has not been drafted by or at the suggestion of the Industrial Commission, it has been submitted to the commission and incorporated in it are the thoughts and suggestions of its staff members.

The panel system. Prior to the legislative session of 1939, the workmen's compensation act provided that employers of three or more employes could not be required to maintain a panel of more than five physicians from among whom the injured employe might make his choice of attendant. The panel must be furnished even though in some instances the only physicians available are not members of the medical society. The State Medical Society of Wisconsin, in cooperation with associations representing both stock and mutual insurance companies writing compensation insurance in the State of Wisconsin, undertook to enlarge the panels through the voluntary cooperation of employers and insurance carriers, in an effort to give the workmen of this state an opportunity to secure virtual free choice of attendant. Through this cooperative effort approximately 80 per cent of the workmen of this state, subject to the compensation act, thus have available to them virtual free choice of physician.

* Reprint (with some corrections and alterations) of pamphlet issued by State Medical Society, June 15, 1940, to its membership. For much of the material the State Medical Society is indebted to Mr. Harry A. Nelson, Director, Workmen's Compensation, Wisconsin Industrial Commission.

In the 1939 legislative session, the statutory limitation as to the required size of the panel was repealed, and the Industrial Commission was given the authority to determine the proper size of the panel through general orders or special orders applicable to given communities. But this amendment does not affect the agreement executed between the State Medical Society and the insurance carriers, under which a conference committee composed of both physicians and insurance company representatives was established. While the committee's responsibilities are manifold, it is important to the physicians who are members of this society that they may avail themselves of the services of that committee as an arbitration medium.

It is contemplated that the committee will function so as to reduce the differences that may arise between the insurance companies and the physician relating to the method of treatment of an injured workman, the charges made by the physician, and similar questions. Conversely, the insurance companies have the opportunity of referring to the conference committee for arbitration, situations in which insurance company officials may be of the opinion that the physician's charges have been excessive or in which the physician has neglected to supply the company with the information to which it is properly entitled.

No formality is required in the cases where either the physician or the insurance companies may have a matter to report relative to the handling or disposition of compensation cases. The secretary of the State Medical Society should be informed of the general nature of the complaint and further information, if necessary, will be acquired that the committee may function to the best advantage possible.

While the committee does not meet regularly, its meetings are comparatively frequent and questions of policy and of the application of the workmen's compensation act are being continually referred to it.

Under the law, of course, the employer is required to post the panel physicians available for treatment. If the employer fails to do this, the effect of certain supreme court opinions is to hold that the injured workman has absolute free choice of physician. The medical panels of those employers, whose insurance is carried by insurance companies participating in the open panel agreement with the State Medical Society, are made up only periodically and so far it has not been necessary to revise these oftener than once each year. A physician who desires to participate in panel listing and who is not now listed may apply to the medical society. In applying to the society, the physician agrees that if he is listed on the panel and engages in treating compensation cases, he will call a consulting physician into the case upon request of the insurance carrier. It is expected that the physician will communicate with the insurance carrier as to the choice of consultant.

The members of the State Medical Society should keep in mind that the effort of their society and the insurance carriers is to provide physicians able and willing to treat compensation cases and to assure to those workmen entitled to the benefits of the act what amounts to a free choice of attendant.

Benefits of the act. The workmen's compensation act is an attempt to provide injured employes reasonable recompense for injuries or diseases received during the course of their employment and to provide them with such medical attention as may be necessary to accomplish the utmost in rehabilitation. The law imposes a liability upon the employer to provide certain indemnities and to provide or pay for necessary medical attention. Because it is in the nature of a liability, those concerned with the compensation act, while they are liberal in its construction, must find three essential elements to exist in order to justify an award to the injured claimant: (1) employer-employe relationship; (2) employer subject to the act; and (3) injury or disease suffered or acquired in the course of employment. With reference to medical care, the workmen's compensation act provides that employers subject to the act must supply any injured employe with "such medical, surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial limbs and appliances . . . as may be reasonably required to cure and relieve from the effects of the injury, not to exceed the period for which indemnity is payable . . ."

Collection of physician's account. It is important to keep in mind that there may be one of two, or two, sources from which the physician may be paid for his services rendered an injured workman entitled to benefits under the act. If the employer himself authorizes the physician to treat the injured workman, then the employer is directly liable to the physician for the expense of that treatment, and that liability continues until such time as it is terminated by the employer's objection to further medical care at his expense.

If, on the other hand, the injured employe himself requested the treatment, without authorization from the employer, then the physician must look to the injured employe for payment, except ordinarily he can expect the Industrial Commission to determine the amount thereof for which the employer is responsible. Where the employer fails to furnish a panel, the injured employe has complete free choice, and the Industrial Commission has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible. In cases where the employe has not given notice of necessity for treatment or has refused to accept a panel physician, the employer has no liability and the commission no jurisdiction to determine necessity or reasonableness but does, upon claimant employe's request, direct payment to the physician of what appears to be a reasonable amount for necessary treatment.

Physician-patient relationship maintained. Generally, of course, communications to an attending physician are privileged and may not be communicated by him. The workmen's compensation act creates an exception to the general law of privilege as any physician, having attended an injured employe who files a claim under the workmen's compensation act, may be required to testify before the commission when it so directs. With reference to this the commission says: "It is a practical necessity that the physician attending the injured workman furnish information to the Commission upon which to base compensation. Physicians will not be required, however, to disclose confidential communications commuted to them for the purpose of treatment and which are unnecessary to a proper disposition of the claim. The Commission regards the physician who treats the injured workman at the request of the employer, to all intents and purposes, the physician of the injured man. His testimony before the Commission should be absolutely fair and unbiased."

The physician acting as expert witness for injured claimant. Not infrequently of course, the claim of an injured workman that he has suffered injury in the course of his employment for which he is entitled to compensation is disputed by the employer or the compensation carrier of the employer. The members of the State Medical Society have no interest, of course, in the technical questions of fact and law which involve other than medical questions. They are interested, however (regardless of whether they may be the attending physician or an expert witness for either the injured workman, or the employer or his insurance company) in the fact that the basis of any claim must depend upon whether the injury or disease was suffered in the course of employment.

In many cases the fact of the injury or disease being suffered in the course of employment is accepted by the employer or the insurance company and the question then is confined to the extent of liability on the part of the employer. In the fields of industrial disease, or diseases attributable to a given occupation, the physician must be prepared to relate the disability to the employe, if such be the case.

Where the claim is controverted by the employer or insurance company either as to causative factor or as to extent, the injured workman frequently calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such case, the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully.

The State Medical Society has received many inquiries raising the question of how the expert witness is paid and to what extent. Before discussing this question in its many implications, certain basic concepts of the workmen's compensation act must be kept in mind. Of primary consideration the claimant must first establish: (1) the employer-employe relationship with both employer and employe subject to the act, and (2) the fact of an injury or disease sustained or acquired by the claimant in the course of such employment.

Second, as stated elsewhere in this memorandum, the employe is entitled, in event of injury and an award therefor, only to recompense for the injury and for the cost of treatment. The award may not be frivolous or capricious and is governed by the strict formula provided in the act itself. The award, or the jurisdiction to grant one, does not involve the unlimited field of a personal injury action but is strictly governed by statutory limitations.

In the third place, it is conceived as the function and responsibility of the Industrial Commission to protect the injured claimant in every proper way. For example, the law does not provide that applicants be represented by attorney in hearings before the commission, but that they may appear in person or by agent. When they appear without attorney, the commission undertakes to do everything possible to assure a fair and impartial hearing. By statute, furthermore, the commission has authority to determine the reasonableness of attorneys' fees rendered by attorneys representing the claimant. By express provision of law, it is illegal for an attorney to charge in any case more than 10 per cent of the award on a contingent basis or a maximum of $100, unless the commission has first authorized such a charge. The commission is authorized, in the interest of a fair and impartial hearing, to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians become witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Finally, the commission directs attention to the case of Philler v. Waukesha County, 139 Wis. 211, to the effect that expert witnesses may not require payment in excess of statutory fees unless work is performed in preparation at the request of a party. The question frequently arises as to whether a physician must obey a subpoena when ordinary witness fees only are paid. Many physicians believe that they cannot be required to do so unless an expert witness fee is paid to them. Our court, however, has held that except as there may be a demand for preparation, etc., every witness, whether expert or otherwise, must obey a subpoena upon payment of ordinary witness fees. (See article on expert testimony at p. 1092 of this issue.)

Because it so frequently deals with the question of physicians' fees, both those in connection with treatment in the case or as an expert, the commission and its staff tend to establish certain levels in the professional work of such physicians. In the case of physicians who are called by the commis-

sion as independent expert witnesses or for the purpose of simply making an examination and report, the Industrial Commission has an established fee schedule under which the services are rendered. This fee schedule is set out under rule 13 and is as follows:

> "Unless otherwise specifically agreed, services of physicians and surgeons rendered at the request of the Commission shall be understood as contracted for on the following terms:
>
> | | |
> |---|---|
> | Minor examination and report, not to exceed | $ 5.00 |
> | Major examination and report, not to exceed | 10.00 |
> | X-rays where necessary to foregoing examination and report, not to exceed an additional | 5.00 |
> | Attendance at hearings on request of Commission: | |
> | for first hour | 10.00 |
> | for each additional hour | 5.00 |
>
> Claims for such services must be paid from the Commission's appropriation and should be submitted on official voucher blanks."

These fees do not, of course, govern the contractual relation between the physician and the claimant, and the physician and the employer, where the physician is called as the expert witness of either. But in those cases in which the physician appears as an expert witness for the injured employe, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Industrial Commission will endeavor to protect the employe, through permitting only what it considers to be a reasonable allowance for the expert. Each bill necessarily depends on the circumstances of the individual case, but the State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness.

With an itemized statement before it, the Industrial Commission is in a better position to judge of the work involved and of the reasonableness of the charges of the physician. While it is true that the Industrial Commission is undoubtedly influenced in establishing the fee schedule for expert witnesses of the state by the fact that payment of these experts is from state funds, yet it seems obvious that such a fee schedule is, in the opinion of the commission at least, generally reasonable.

In the case of state employes who file compensation claims, the commission is explicit in its demands for itemized medical statements and for verification of the reasonableness of the charge:

> (Rule 18)
>
> "No claim for compensation or medical aid by an employe of the state will be allowed until the following reports and statements have been furnished to the Commission:
>
> * * *
>
> "(2) A sworn statement by the injured employe to the effect that he was injured in the course of his employment and reciting the time and place of the injury, the reasons for its occurrence, and the nature of the injury, and also setting forth *in detail* the expenditures incurred for necessary medical, surgical and hospital treatment and medicines, (if these bills were paid by the injured, receipts must be attached) . . .
>
> * * *
>
> "(4) A sworn statement from the physician and the hospital itemizing the service rendered and the charges therefor . . .
>
> "(5) A letter from the employing department, stating its recommendations upon . . . (b) the necessity for the medical, surgical and hospital treatment, (c) the reasonableness of the bills incurred for such treatment and for medicines; . . ."

Physicians must keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employe for payment. Furthermore, where a physician treats an injured employe and such treatment has not been authorized by the employer, and the Industrial Commission finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Estimating of Permanent Disability Under the Wisconsin Workmen's Compensation Act

With a general broadening of panels of physicians for the purpose of treating injured employes under the Wisconsin workmen's compensation act, it becomes desirable for physicians to have a clear understanding of the estimating of permanent disability under terms of the act. A study of the act as to benefit provisions, and particularly of the provisions of Sections 102.42, 102.43, 102.44, 102.52, 102.54, 102.55, 102.555, and 102.565, is recommended. Copies of the compensation act in pamphlet form are available and will be forwarded by the Industrial Commission to any interested physician upon request.

Under the provisions of the workmen's compensation act, injuries may be divided into two types for the purpose of estimation of permanent disability, i. e., non-schedule and schedule injuries.

Non-schedule injuries. Non-schedule injuries are those to some portion of the body other than the legs, arms, ears or eyes, or their constituent parts. Generally speaking, non-schedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

In the case of non-schedule injuries permanent disability is based upon wage loss consisting of such percentage of the average weekly earnings of the injured employe computed according to the provisions of the compensation act "as shall fairly represent the proportionate extent of the impairment of the injured's earning capacity in the employ-

ment in which he was working at the time of the injury, and other suitable employments, the same to be fixed as of the time of the injury, but to be determined in view of the nature and extent of the injury." (Sec. 102.11(3) Stats.) If the disability is such as to render the employe unable to perform substantially all the material duties of his own occupation, or of any other remunerative occupation which his age, training, experience, education and physical condition would fit him for, except for his disabling infirmity, his disability is total. The Wisconsin Supreme Court has held that a man's wage earning capacity is to be distinguished from his capacity to make money in a business conducted under his supervision or direction, and with the use of investment of other capital than that which arises from his own labor. The question thus resolves itself into one of employability, using care to distinguish the non-employability resulting from the employe's physical condition from that which results because of economic conditions or other circumstances which might limit employability regardless of the employe's physical condition. In the case of one who is fitted to perform labor only, a back injury of a certain severity may cause considerable wage loss, while in the case of one suited for clerical work the same physical disability, in terms of wage loss, would be much less serious. The limitation in capability to work within a limited field of employment must be considered in determining the percentage of impairment of earning capacity. With such double limitation the probability of wage being earned by the employe is obviously more largely curtailed and probable wage loss is greater.

Schedule injuries. Schedule injuries are estimated upon a different basis, which bears no relation to wage loss. In these cases *the comparison is as between the injured limb and a normal limb*, having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes and ears, as well as any constituent part of these members and organs. The estimate of disability takes no regard of any particular occupational use to which the member is to be put. The violin player who has lost a digit vital for the purpose of playing, and who may consequently lose much wage, receives exactly the same number of weeks' compensation as does the laborer who may be able to perform his work nearly as efficiently as before, even with the loss of a digit. The law fixes the value of each finger, thumb, toe, hand, arm, foot and leg at various joints. In the estimation of disability the doctor takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists, or if disability is between joints, at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the arm with a normal arm at the elbow, or, put conversely, with an arm which has been amputated at the elbow.

Because in every case of schedule injury, where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases, the estimate in such cases should be uniform. If the employe has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted.

In case of schedule injuries the commission has found it possible to establish by custom or rule the related disability applicable to a given handicap. After many hearings with physicians, and in cooperation with the State Medical Society, the commission has adopted a schedule of related disabilities to serve as a guide in rating disabilities short of amputations or total loss of all function. In the example cited, where the loss of function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20 per cent of the arm at the shoulder.* In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. *If, for example, in addition to limitation of motion, there is disabling pain or weakness, a percentage must be added for these elements.* As the commission has adopted landmarks only for loss of certain specified functions representing disability, the physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability.

As a guide for the estimating of disabilities the commission has adopted the following table *representing per cent of loss of use as compared with amputations at involved joints.*

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90°, but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis

	Mid-position	Complete Extension
Thumb		
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle and proximal joints	100%	100%

Loss of Motion

Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10%	= 1%	10%	= 2%
	20%	= 2%	20%	= 4%
	30%	= 3%	30%	= 6%
	40%	= 5%	40%	= 8%
	50%	= 10%	50%	= 15%
	60%	= 15%	60%	= 20%
	70%	= 20%	70%	= 30%
	80%	= 25%	80%	= 40%
			100%	= 60%
Middle joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 10%
	40%	= 25%	40%	= 15%
	50%	= 40%	50%	= 30%
	60%	= 50%	60%	= 50%
	70%	= 60%	70%	= 70%
	80%	= 70%	80%	= 90%
			100%	= 100%
Proximal joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 15%
	40%	= 20%	40%	= 20%
	50%	= 25%	50%	= 25%
	60%	= 30%	60%	= 40%
	70%	= 35%	70%	= 75%
	80%	= 40%	80%	= 85%
			90%	= 100%

(Where there is partial disability to two or more phalanges the estimate of the physician should take into consideration the greater cumulative effect because of such multiple disabilities. By analogy the allowances for complete ankylosis, where two or more joints are affected, may be used as a guide for comparison as to the greater allowance to be made because of the combined disabilities to two or more phalanges.)

Hip

Ankylosis in alignment for normal standing position ---------- 50%

Shortening of leg (no posterior or lateral angulation, age 50 or less)

1 inch ---------- 7%
1½ inches ---------- 14%
2 inches ---------- 22%

(The percentages compare loss of the leg at the hip.)

Knee

Ankylosis at 170° ---------- 40%
Limitation of motion, remaining range 135°–180° ---------- 20%

Ankle

Ankylosis at right angle ---------- 30%

Report form. For use in reporting disabilities under the compensation act the commission has adopted a form for use of physicians (see Form A–16 reproduced herein).

In order to enable the commission to pass upon disability it becomes neecssary that the physician's report contain as a minimum all of the information requested by this form. If in any case use is not made of the form, the physician should make certain that the requirements of the form are met. That will save returning the form to the physician with request for supplementary report.

In addition to this form the commission also makes use of a form for use in cases of loss of vision, which will be supplied to physicians upon their request, together with rules for determining loss of visual efficiency caused by industrial injury. In the case of partial deafness, no fixed rule has been adopted for determination. The physician should make use of recognized standards in reaching an estimate as to the percentage of loss of hearing which has resulted.

In the estimating of disabilities to members included within the schedule group, it should be remembered that 50 per cent loss of motion, or 50 per cent loss of strength of itself does not necessarily mean 50 per cent loss of function of the limb. All functions of the limb must be considered, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, etc. To each factor must be assigned by the physician the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member, and to each factor must be applied the percentage of loss of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

In those cases in which loss of motion is greater or less than that represented by the landmarks established by the commission, the physician must add or subtract such percentage as he believes will fairly represent the greater or smaller percentage of disability found to have resulted. In making his estimate the physician will be guided by the landmark laid down for the most nearly comparable disability for which a landmark has been established.

The cooperation of physicians is earnestly solicited by the commission in the making of prompt and complete reports to employers and insurance carriers, making it possible for them to pay compensation speedily and without interruption when due to employes. The commission feels that those physicians who, because of press of other business, or because of a lack of desire on their part to participate in the compensation program, find it impossible to do justice to the parties, or to make all necessary reports promptly, should not be included in panels for the purpose of treatment of injured employes. Physicians have it within their

Industrial Commission of Wisconsin, Form A-16

PHYSICIAN'S REPORT ON ACCIDENT OR INDUSTRIAL DISEASE

Name of Employe _____

Name of Employer _____

Date of accident or first illness _____

Nature of injury _____

_____

Date injured was released from treatment _____

Date injured was able to return to full time employment at former occupation _____

Has accident or industrial disease resulted in any permanent disability? _____

Has accident or disease resulted in disfigurement?_____ If so, describe _____

_____

_____

Describe permanent impairment resulting from accident or disease. (Where practical, make use of diagram on back of report) _____

_____

* How will disability affect employe in his work? _____

_____

* What sort of work will he be unable to perform? _____

_____

(* Two questions above need to be answered only in case of injury to head or torso)

What elements constitute disability (such as limitation of motion, deformity, weakness, pain, lack of endurance, etc.) _____

_____

If limitation of motion, describe nature and percentage of limitation of each member or constituent part. (Estimates will be made on voluntary, not passive motion) _____

_____

_____

If accident caused injury to more than one of the constituent parts of the hand or foot, state healing period separately for each part _____

_____

Previous to this injury, did employe have any permanent disability?_____If so, describe_____

_____

_____

If amputation, state date _____(Mark point of amputation on diagram)

1. Has stump good, hardy pad or a tender pad? _____
2. Is there any restriction of motion in remaining joints? If so, state degree _____

_____

_____

What improvement, if any, is anticipated? _____

_____

What, if any, further treatment should be given? _____

_____

Remarks _____

_____

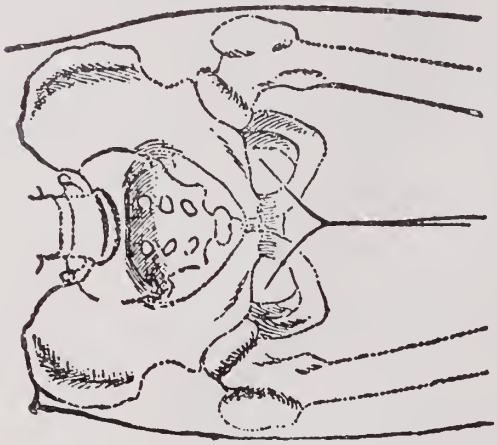
_____

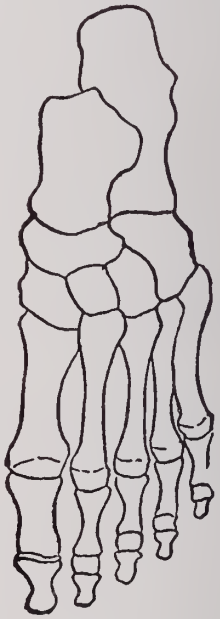
Dated at _____ this _____ day of _____ 19___

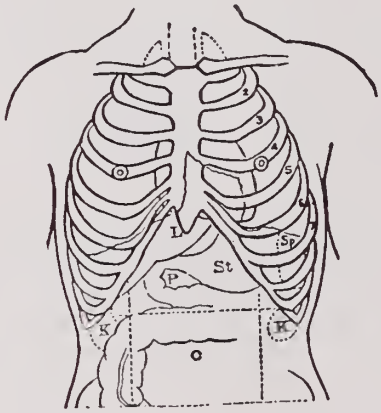
Signature of physician _____

(Required in doctor's own handwriting)

HAVE YOU MARKED DIAGRAM ON BACK OF REPORT?



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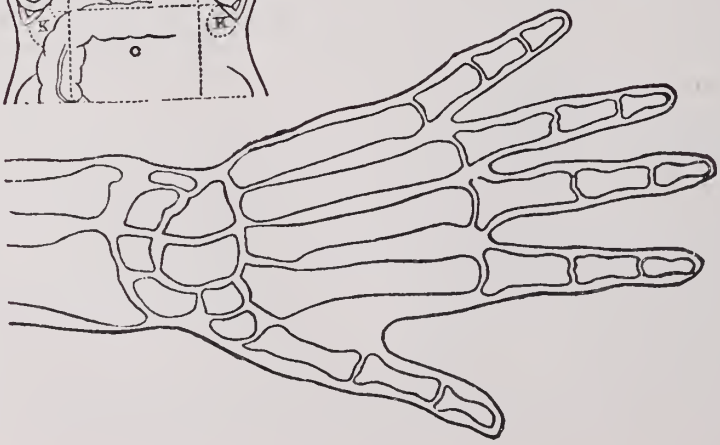

power to hasten or delay the payment of compensation which is clearly due. Time is of the essence under the workmen's compensation act in the payment of compensation to those who usually are in urgent need because of their unexpected misfortune.

As it is the commission's ultimate function to fix the percentage of disability, full reports covering all factors should be made, setting out in detail the elements which constitute disability, and stating as nearly as possible the weight and percentage of loss which has been ascribed to each. The physician should also set out his opinion as to the ultimate total percentage of disability which has resulted. That enables the commission to check the report with the commission's standards and to arrive at an intelligent and uniform conclusion.

It has not been the purpose of this resume to conduct an exhaustive analysis of the law in the many ways in which it may be related to the physician and his patient. Many questions will doubtless remain in the physician's mind.

But if the panel physician will appreciate the technical detail of much of the law and its administrative characteristics, he will find it easier to deal with the employer, the insurance carrier, and the patient. Both the office of the State Medical Society and the Industrial Commission will be happy to be of assistance in the medicolegal problems confronting the physician who treats patients entitled to, or claiming, benefits under the act. Inquiries may be directed either to the State Medical Society or to Mr. Harry A. Nelson, Director of Workmen's Compensation, State Capitol Annex, Madison, Wisconsin.

Agreement on Panel Practice

At the suggestion of the insurance companies selling workmen's compensation insurance in Wisconsin the State Medical Society of Wisconsin entered into a joint agreement with them to permit employes eligible to benefits under the workmen's compensation act to have free choice of physician. Through the medium of this agreement any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employes may have his name included in the panel which is certified to the insurance companies. This agreement makes it possible for from 75 to 80 per cent of the employes in Wisconsin to have a wide choice of physician.

The attention of members is specifically called to the provision under the application for placement on panels that the member agrees to have consultation when so requested by the insurance carrier. The member also agrees to communicate with the insurance carrier in regard to the consultant in order that the consultant might be mutually agreed upon. It is recognized that exceptions will occur to this portion of the agreement, but the exceptions should occur only in the event of an emergency.

The agreement on panel practice in Wisconsin as adopted by the Council of the Society and the insurance company associations is as follows:

Agreement on Panel Practice in Wisconsin

The workmen's compensation law of Wisconsin requires all employers to maintain a panel of five physicians, from which an injured employe shall have the right to make choice of an attending physician in case of accident. In many communities the common interests of the employer, the injured employe and of the medical profession will be more equitably served by liberalizing the minimum statutory requirement. In order to provide a larger medical panel from which the injured employe may select his attending physician, representatives of both the stock and mutual insurance companies writing compensation coverage in the State of Wisconsin, and representatives of the State Medical Society of Wisconsin, established the following principles:

1. The State Medical Society will prepare, and make available to insurance carriers, panels listing the names of all those physicians in each component county society desiring to accept employes eligible for treatment under the workmen's compensation act. This list and the panels will be kept as accurate as possible, but need not be revised more often than January 15 and July 15 of each year. If any panel distributed by an insurance carrier includes the names of any physicians not members of the State Medical Society, nothing thereon shall indicate that it has been approved by said Society.

2. A State Conference Committee of four, two representing insurance carriers and two representing the State Medical Society will be established, whose function it will be to coordinate the obligations of the insurance carriers with the facilities of the medical profession to provide proper benefits to injured employes. Specifically such committee shall have the duties of:

a. Mediating, if possible, those cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary.

b. Mediating, if possible, those cases where it is complained that the insurance carriers have unreasonably interfered with what is properly in the discretion or control of the attending physician.

c. Reviewing any situation in which it is claimed that there has been a violation of medical ethics and, in its judgment, referring any facts relative thereto to the Board of Censors of the County Medical Society.

d. Mediating, if possible, differences that may arise between the attending physician and the insurance carrier relative to remuneration.

e. Hearing any complaints relative to the competency of those serving on such panels and removing their names therefrom if, upon investigation, it is found that such complaints are justified.

In the event of complaints from either insurance carriers or physicians the State Conference Committee may designate a special local committee to investigate and report to the State Conference Committee with recommendations as to the action to be taken. Both the State Conference Committee and the special local committees will attempt to mediate only those cases wherein the physician involved is on the listing provided by the State Medical Society.

3. It is understood that this is a trial plan and is necessarily limited to the State of Wisconsin. Any modifications of this general statement of principles to be effective must be approved by the State Conference Committee.

Procedure of the U. S. Employes' Compensation Commission in the Administration of Benefits to W. P. A. Employes*

ALL workers on W. P. A. projects are employes of the United States government and all compensation matters arising out of injuries to W. P. A. workers are within the jurisdiction of the U. S. Employes' Compensation Commission. There is no appeal from the decisions of the commission. However, under certain circumstances, the commission will reconsider a closed case. All matters concerning W. P. A. injuries are cleared to the U. S. Employes' Compensation Commission through the state compensation officer, located at 149 East Wilson Street, Madison, Wisconsin.

Physicians are often confused between the procedure of the Wisconsin Industrial Commission in the administration of compensation under the workmen's compensation act of Wisconsin, and that of the U. S. Employes' Compensation Commission under the U. S. Employes' Compensation Act. Hereafter, the workmen's compensation act of Wisconsin will be referred to as the Wisconsin act, and the U. S. Employes' Compensation Act will be referred to as the federal act.

The following are the more important distinctions between procedure under the Wisconsin act and the federal act. The former is ably treated in the pamphlet published by the State Medical Society on June 15, 1940. See reproduction, p. 1039 of this issue.

1. In amending the U. S. Employes' Compensation Act of 1916, Congress limited the benefits of that act, in applying it to W. P. A. injury cases, to disability resulting from a traumatic injury. A traumatic injury was defined by Congress as follows:

> *"Traumatic injury shall mean only injury by accident, causing damage or harm to the physical structure of the body, and shall not include disease in any form except as it shall naturally result from the injury."*

It will immediately become apparent that this limitation rules out industrial ailments and diseases which are covered by the Wisconsin act. To illustrate briefly, a back strain, or tenosynovitis, which results from a series of exertions such as lifting or handling heavy objects, where there is no accidental occurrence connected with the onset of pain, is not ordinarily considered compensable under the federal act, as amended to cover injuries to W. P. A. workers.

2. W. P. A. project employes are entitled to medical treatment and compensation benefits, if injured while going to or coming from their employment on the project. This regulation was adopted by the U. S. Employes' Compensation Commission on July 8, 1937, and has been extended to cover W. P. A. security workers under subsequent appropriation acts. In applying the rule, the federal commission has indicated that W. P. A. project workers who sustain injury while going to or coming from work are entitled to compensation benefits (including medical treatment) if the route traveled was the most usual and direct, and if no substantial deviation from such route is indicated. This regulation is an anomaly in the history of workmen's compensation, and substantially differs from the regulations under the Wisconsin act. Reference is made to this regulation in order to apprise physicians that W. P. A. project officials may authorize medical treatment in cases where it would normally appear that a worker was not in the performance of duty at the time the injury occurred.

3. The U. S. Employes' Compensation Commission holds no hearings on W. P. A. injury cases. Investigations are made and decisions are rendered entirely from written proof submitted to the commission through the state compensation office.

4. All medical and hospital bills incurred in the course of treatment of W. P. A. employes are paid by the U. S. Employes' Compensation Commission from a fund specifically provided for this purpose by Congress, and the U. S. Employes' Compensation Commission passes on the reasonableness of charges submitted by physicians. Under the Wisconsin act, charges for medical treatment and compensation are paid by the workmen's compensation insurance carriers or the employers, if self-assured; consequently, the Industrial Commission generally does not pass on the reasonableness of charges submitted by physicians. There is no schedule of fees covering various types of treatment of W. P. A. injury cases, but the U. S. Employes' Compensation Commission *will pay medical fees at rates not in excess of the minimum charge prevailing in a community for similar services.* There is a schedule covering hospital charges for injured W. P. A. employes which will be supplied by the state compensation officer upon request.

5. W. P. A. injury cases must be referred to federal medical facilities, insofar as they are available without disadvantage to any other beneficiary for whom the United States government medical facilities have been specifically provided. Hernia

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* Prepared for the Wisconsin Medical Journal by Mr. J. C. Gamroth, Madison, State Compensation Officer, Federal Works Agency, Work Projects Administration of Wisconsin.

cases are generally referred to federal hospitals for operation.

6. Where no United States government medical facilities or hospitals are available, under the regulations of the U. S. Employes' Compensation Commission W. P. A. injury cases requiring medical treatment must be distributed among the private physicians in a locality in as equitable a manner as possible. Free choice of physician, especially as to family physicians, is accorded the injured wherever possible, except in cases where there may be an unequal distribution of cases and where the physician already may have had more than his share of cases, which very seldom occurs. Any complaints regarding unfair or inequitable distribution of W. P. A. injury cases among doctors in any locality should be promptly reported to the state compensation officer.

Authorizations; Classifications

In cases where it is reasonably clear that a given injury resulted from an accidental occurrence while in the performance of duty on the project or while going to and from work, ordinarily the project timekeeper authorizes *all necessary medical treatment* at the expense of the government on a form known as Special Form CA–16, designated for this purpose. This authorization includes x-ray services, if necessary for diagnostic purposes, and hospitalization, if needed. This authorization also provides a physician with authority to call in a specialist and a special nurse in serious cases where needed. Major surgery at government expense should not be undertaken by the attending physician without special authority from the U. S. Employes' Compensation Commission. In an emergency, where immediate surgery is found necessary to save the injured worker's life, the state compensation officer should be contacted by long-distance telephone or telegraph for authorization of such surgery.

The following types of cases are always considered doubtful, and medical treatment should not be authorized by project timekeepers until there has been a medical examination and report and until approval of medical treatment has been forthcoming from the state compensation officer:

1. Hernia
2. Sprains and strains of any nature
3. Sunstroke, heat exhaustion or heat prostration
4. When the accident alleged to have caused the injury occurred while the employe was traveling to or from the project by a route not considered the most direct and usual route to be traveled between the employe's home and the project.
5. When the employe fails to report the accident alleged to have caused the injury within thirty days from the date of its occurrence.

When a W. P. A. worker applies to a physician for treatment without any written authorization, the physician should request him to procure an authorization from his official superior, usually the timekeeper. Authorizations for medical treatment cannot be issued retroactively. However, any physician who treats an injured W. P. A. worker without an authorization has the privilege of submitting his charge to the state compensation officer who forwards the bill to the U. S. Employes' Compensation Commission for its consideration. Under certain circumstances, the commission may pay for medical treatment even though it is rendered without an authorization.

Project officials frequently are not able to diagnose conditions for which treatment is oftentimes sought. It is inevitable that authorizations for treatment will at times be erroneously issued by project officials for conditions which examination by the attending physician discloses are not the result of a traumatic injury as above defined, but are attributable to other pathological causes, and, hence, fall into the category of doubtful cases in which no treatment should be rendered at the expense of the government. In such a case the doctor should advise the injured that it is his opinion that the condition is not the result of a compensable injury, and that further treatment must be a personal matter between the doctor and the patient regarding payment for such services. In the event of allowance of treatment, the charges may be submitted to the commission for its consideration, through the facilities of the State Compensation Officer. In such a case, the physician should immediately forward his medical report to the project timekeeper for transmission to the state office before continuing with any treatment.

The injured is usually sent to the doctor with an original and copy of the form CA–16, authorization for treatment. The hospital or physician may retain one copy for his or its records, and the physician should then return the original to the timekeeper who makes an additional copy and submits the original and copy to the state compensation office.

Where a worker with an ailment of a doubtful nature is sent to a physician under form CA–17 *for examination only*, and the physician finds it necessary to resort to the use of x-rays for the purpose of completing his diagnosis, this authorization will cover the expense of such x-ray films and report.

Where a patient has once been discharged by a physician and, at a later date, requests further treatment, no medical treatment or examination can be authorized where (a) the case has been disallowed by the commission, (b) final payment of compensation has been made by the commission, (c) the employe lost no time from work and the case has been closed more than six months, or (d) the commission has made an award for partial, permanent disability. In such cases the physician should advise the injured to either contact his official superior or write to the state compensation office and the case will then be given further consideration.

Cases of eye injury are usually referred to an eye specialist for treatment where one is available, but where no eye specialist is available and the case is referred to a general practitioner, he may, if he considers it necessary, send the injured to an eye specialist in another city. However, eye glasses are not to be furnished at government expense until authorized by the U. S. Employes' Compensation Commission.

Because of the definition of a traumatic injury adopted by Congress as quoted above, the following types of ailments or injuries are clearly outside of the scope of the above mentioned act:

No authorization for either examination or treatment can be given where injury or death results from wilful misconduct of the injured employe, or by his intention to bring about the injury or death of himself or another, or where intoxication of the injured employe is the proximate cause of the injury or death.

Sunburn, cement burns and kindred inflammations of the skin are not considered traumatic injuries within the meaning of the federal act, and medical treatment at the expense of the government cannot be authorized. However, if an accidental injury such as a scratch is aggravated by the presence of cement, such a case may be recognized by the commission as compensable.

Medical Reports; Physician's Compensation

Frequently the medical report of the attending physician is inadequate. A sufficiently clear description of the objective and subjective findings and estimates of periods of disability during which the injured worker would not be able to do light work or regular work are necessary. Where the injured does not respond to treatment as anticipated, and disability and/or the period of treatment is prolonged due to any untoward developments, the attending physician should supplement the routine report called for by the forms with an explanation of causes for such prolonged disability and/or treatment.

Failure of a physician to submit his report of preliminary examination likewise delays handling of such claims. The need for prompt payment of compensation to W. P. A. employes is apparent in view of their low earnings. The forms supplied to the doctor are so designed as ordinarily to supply the necessary information. As soon as the medical report is completed by the attending physician, it should be forwarded to the timekeeper of the project on which the worker was injured, where copies are made and transmitted to the state compensation office.

Unlike the Industrial Commission, the U. S. Employes' Compensation Commission passes upon the reasonableness of the charges submitted and pays the medical bills from funds appropriated for that purpose. The U. S. Employes' Compensation Commission is usually liberal in the matter of payment of fees and in permitting physicians to submit explanations of their charges where they may appear to be excessive. A complete itemization by the physician of all services rendered in a case and listing of charges by unit will definitely insure full consideration of all the services rendered by the physician and the charges submitted therefor. All the medical bills in W. P. A. cases are usually paid by the commission within two or three months of the date of submission. Physicians are urged to submit their vouchers promptly upon termination of treatment. However, if treatment exceeds thirty days, the commission requires that the physician submit a voucher for every thirty-day period of treatment along with a special detailed medical report. In this way the payment for services rendered by an attending physician need not be delayed, in cases of prolonged treatment, until the final treatment is rendered.

Physicians are urged to forward their vouchers immediately upon completion of treatment to the timekeeper of the project on which the injury occurred, as all vouchers must be endorsed by him. However, if the identity or location of such project timekeeper is not known either to the injured or his physician, the vouchers may be forwarded directly to the state compensation office, but the submission of such reports or medical bills on form S–69 should not be delayed unnecessarily due to inability to locate the timekeeper or the injured. Under no circumstances should a physician forward any vouchers for services rendered or any medical reports directly to the commission at Washington; this merely delays action on them for lack of the timekeeper's endorsement.

Whenever any question arises in the mind of a physician regarding procedure in connection with a W. P. A. injury case, the physician is urged to communicate with the state compensation office for an adjustment or explanation of the difficulty. It is important to W. P. A. employes that the good-will of the physicians be maintained and that the most easily accessible physicians and medical facilities be available to them.

There are other federal compensation acts, such as the Federal Employes Act, covering workers in interstate commerce, and the Longshoremen's Act, covering maritime employment. However, in the absence of confusion between these and other acts, and in view of the small number of employes in Wisconsin coming under these acts, no attempt has been made to discuss them.

The physicians and surgeons of Wisconsin have admirably cooperated in the administration of compensation benefits under the U. S. Employes' Compensation Act as applied to W. P. A. project workers. A great deal of credit for this cooperation is due to the willingness and untiring efforts of the State Medical Society of Wisconsin in giving important phases of the Federal Compensation Act, as applied to the W. P. A. employes, publicity through the Wisconsin Medical Journal, and in according opportunities for compensation representatives to discuss these problems at regional and county medical meetings.

Privileged Status of Testimony of Physicians and Surgeons in Legal Proceedings

THE present law relating to privilege accorded the testimony of physicians and surgeons in Wisconsin courts is as follows:

325.21 **Communications to doctors.** No physician or surgeon shall be permitted to disclose any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to serve such patient, except only (1) in trials for homicide, . . . (2) in all lunacy inquiries, (3) in actions, civil or criminal, against the physician for malpractice, (4) with the express consent of the patient, or in case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life, health, or physical condition.

This statute refers only to the testimony of a physician or surgeon in legal proceedings, and is to be distinguished from section 147.20 (d), Wis. Stats., which provides for revocation of the license of a physician or surgeon for wilfully betraying a professional secret. Testimony within the protection of the statute includes information given by the patient in good faith, even when the physician or surgeon could have diagnosed and prescribed without it, and may include the physical circumstances of an injury and its occurrence, or the previous condition of an injured part of the body if, in the opinion of the physician or surgeon, such information is necessary to enable him to treat the patient.

The law relating to privilege is statutory and has no basis in the common law. Accordingly, the tendency of the court is to interpret the statute strictly and literally and to enforce only such restrictions as the statute specifically imposes, and not to add restrictions which the legislature may have omitted. As a result, certain interpretations and constructions of the statute have been made which are important to know.

For a long time the Wisconsin Supreme Court has adhered to the doctrine that a physician or surgeon may testify, or may be compelled to testify, to a condition observed by him when unconnected with treatment, even when the person observed or examined for purposes other than treatment is or was a patient of the physician. Following this principle the court has held that a physician or surgeon may testify as to a death certificate made by him, or as to an autopsy performed by him.

In a recent decision the court has held that a nurse could testify as to a record made by her at a patient's admission and during his treatment, in spite of the fact that the record was used by the doctor in treating the patient, because the statute specifically names only physicians and surgeons. For this same reason, testimony of an interne attendant or x-ray operator or the x-ray plate made by him is not privileged.

The privilege of the statute may be waived by the patient himself, or by his personal representatives or by beneficiaries of an insurance policy. Although it might appear from a reading of the statute that waiver by a personal representative is to be permitted only in personal injury cases, nevertheless, the court has very recently held that the personal representative may waive the privilege and introduce the testimony of a decedent's physician as to the health and physical condition of the decedent prior to death in a case involving a tax on gifts made in contemplation of death.

In addition to the privilege statute itself, there has been since July 1, 1939, a rule promulgated by the Supreme Court which has the force of statute and reads as follows:

The court or a presiding judge thereof may, upon due notice and cause shown, in any action brought to recover for personal injuries, order the person claiming damages for such injuries to submit to a physical examination by such physician or physicians as such court or a presiding judge may order and upon such terms as may be just; and may also order such party to give to the other party or any physician named in the order, within a specified time, an inspection of such X-ray photographs as have been taken in the course of the treatment of such party for the injuries for which damages are claimed, and inspection of hospital records and other written evidence concerning the injuries claimed and the treatment thereof; and if compliance with the portion of said order directing inspection be refused, the court may exclude any of said photographs, papers and writings so refused inspection from being produced upon the trial or from being used in evidence by reference or otherwise on behalf of the party so refusing. Sec. 269.57 (2).

This rule is restricted to personal injury cases. That part which deals with a physical examination of the injured party is not inconsistent with the privilege statute because the examination is being made not for treatment but for a purpose independent thereof. As to its effect on introduction of records in a trial, it will be noticed that the order does not compel a party to permit inspection of such records and written evidence, but provides a penalty in case of refusal in that the party refusing may not himself use them or produce them in the trial.

Among the more common situations arising today in which the physician is asked to disclose privileged information are those in the pre-employment or periodic health examination of employes, and those in which an insurance company seeks information to serve as a basis for writing a policy in favor of the patient or for adjusting a claim made

by a patient who may carry health, accident or sickness care coverage. For his own protection, the physician must always obtain the signed authorization of the patient before divulging such privileged communications. Such authorization should also identify the person or organization to which such disclosure may be made, and should specify the information to be disclosed. The physician should not disclose information beyond that permitted by the authorization, for if he should go beyond the limits of the patient's waiver, he may be charged with wilful betrayal of a professional secret. Insofar as the periodic health examination or pre-employment examination of employes in industry is concerned, the State Society has perfected a specific form of release which appears on model examination forms, approved by the Industrial Commission. These forms are available through the State Medical Society at the cost of printing.

While it is difficult to express a general principle, a physician who is rendering a bill to poor relief authorities for professional services rendered relief patients should avoid reporting details beyond those absolutely necessary for reimbursement.

Legal Status of Internes and Externes

BEFORE discussing the legal status of internes and externes, it is first necessary to consider the definition of the terms, as used in Wisconsin. Little help in answering this question can be gained from the medical licensure act, chapter 147. The act makes no mention whatsoever of externes and only briefly refers to internes. The term "interne" is generally understood to apply to one who is engaged in a twelve-month period of advanced study and apprenticeship immediately subsequent to the completion of his college course and prior to the granting of his license. Section 147.15 makes it a prerequisite for granting of a license to practice medicine and surgery. The term, however, is sometimes loosely applied to the second and third year following the completion of the required period of interneship, during which similar studies are continued, but after the first year, unless his medical school requires a longer interneship as a condition of graduation, the interne must be licensed and have the legal status of a practicing physician. In this discussion, "interne" will be limited to those in the first year of interneship.

The term "externe" is professionally applied to those advanced medical students who have not as yet reached the interne stage, or been licensed to practice medicine, but who are performing certain assisting and observing functions, either during a vacation period or during their fourth year of medical study, under the supervision of a licensed physician. Externes enter into this course of training under an arrangement between supervising physicians and the medical school. The hospital has no jurisdiction over them.

It is apparent then, that neither externes nor internes have the full legal status of licensed practitioners. Accordingly, the scope of their functions is correspondingly more confined. Their legal status has never been specifically passed upon by the courts, nor has the legislature seen fit to define their powers and duties, the matter being left entirely in the hands of the medical profession. That an interne has certain functions of a medical nature which he is permitted to perform is recognized by the Wisconsin Supreme Court, in the case of Nickley v. Eisenberg, 206 Wis. 265. The court there admitted that internes are not subject to the medical practice act, in that they may perform "such duties as are usually and ordinarily performed by them." It gave tacit recognition to the accepted practice performed by internes, pointing out that the legislature considered it essential to their professional training. In the same opinion, the court recognized the legal status of certain nurses who were not registered under chapter 149. By the same reasoning, externes would probably have a recognized status in the medical profession. But their status is such that neither internes nor externes are within the provisions of the so-called "privilege statute" under the case of Borosich v. Metropolitan Life Insurance Company, 191 Wis. 239.

The further question arises as to those responsible for mistakes made by internes or externes while performing their customary duties. That they are personally responsible for their negligence, is, of course, conceded, and this liability may extend to physicians under whom they are working or to the hospital employing them. The law generally holds the interne to be an employe or servant, inasmuch as he is obliged to spend his days and nights at the hospital to render any administrative or medical service exacted by the hospital to its agents within the range prescribed by propriety and custom. This interpretation of his position is recognized by the courts under the workmen's compensation act, which extends employe protection to internes injured in the performance of their duties in the hospital.

Wisconsin has held that the hospital is responsible for liability arising out of the acts of internes in the performance of duties which are customarily performed by them. Exemption, however, has been made in the case of charitable hospitals which are protected by law for the acts of their employes or servants. See Schumacher v. Evangelical Deaconess Society, 218 Wis. 169; and Kuglich v. Fowle, 185 Wis. 124. However, where the interne is acting under the direct supervision of a physician or surgeon during the course of an operation, the hospital is

absolved from responsibility and his acts become those of the surgeon or physician who has charge of the work.

An externe, as was pointed out, is generally an assistant of a physician and has no relationship to the hospital. Because the duties delegated to an externe by a physician are generally very much limited, extending only to observation, a situation would seldom arise in which an act of an externe might cause injury. A physician would presumably have the duty to see to it that the externe be delegated no duty which would call for discretion or judgment on his part, but should he be negligent, the responsibility for his acts would doubtless be that of the physician.

Restrictions on Practices of Cultists

THE legislative records of Wisconsin are replete with the efforts of osteopaths, chiropractors and other cultists to secure an extension of privileges and of practices denied them by present operation of law. Failing in these repeated attempts, many practices not permitted by law nevertheless have been attempted or followed by many of the cultists without regard to the restrictions of their licenses. This article is directed to the purpose of summarizing the more important public health restrictions now affecting these practitioners both as to the extent of practice permitted them and in the assumption by them of titles or designations that would tend to confuse their limited privileges with those duly licensed to practice medicine and surgery.

Chiropractic Practice

"Chiropractic" is defined as the "adjustment of, ordinarily, the spinal column, and ordinarily only by manipulation by the hand; also, that chiropractic does not include the use of any medicines or drugs, nor surgery, nor the use of any devices which do other than adjust, if indeed, it permits mechanical apparatus even for adjustment."[1] Chiropractors have advertised themselves as devoted to a theory that their practice is "a philosophy, science and art of things natural; a system of adjusting the articulations of the spinal column, by hand only, for the correction of the cause of disease. This definition is inclusive and any and all other methods are declared not to be chiropractic. All else belongs to other methods."[2] Licensed only as chiropractors, the practice of these cultists is confined to chiropractic. This is a proper ruling, as to "permit them to do more than that is to turn loose a group of incompetents in the use of methods for which they are incompetent, and work a hardship on the public."[3]

Restrictions on chiropractic practice.—Chiropractors in Wisconsin are not available for the treatment of workmen's compensation cases, for a chiropractor "is not a physician as that term is used in the (compensation) act and in Ch. 147."[4] One licensed only as a chiropractor in Wisconsin, who uses electrotherapy in the course of treatment violates the medical practice act.[5] Nor can chiropractors administer medicines or drugs nor use any therapeutic methods other than adjustment of the spinal column by hand.[6] Chiropractors are not privileged to disregard the quarantine of communicable diseases as they are not physicians under the Wisconsin law.[7] A chiropractor is not permitted to perform electrocoagulation of the tonsils.[8] And, not being a physician, he cannot sign death certificates,[9] and, by analogy, other health records.

Chiropractors and use of title "Dr."—The Supreme Court of Wisconsin has upheld numerous opinions of the Attorney General holding that the Wisconsin law forbids the use of the title "doctor" by chiropractors. In an opinion by Chief Justice Rosenberry, the court said:

". . . It is apparent that for more than fifty years the use of the term 'doctor' has been restricted in the State of Wisconsin, and the right to the use of the term has become associated with those who were entitled to practice medicine, surgery, or since 1903 osteopathy. The evident purpose . . . is to prevent imposition upon the general public by the use of that term by those who were not authorized to use it under the statute . . .

". . . The statute was rewritten and revised to make it clear that those practicing chiropractic could not hold themselves out as a doctor or append to their names the title of doctor because, in Wisconsin at least, that would tend to represent them as a doctor authorized to practice medicine, surgery, or osteopathy. It would tend to lead the public to the conclusion that persons so announcing themselves were qualified physicians, surgeons, or osteopaths as well as chiropractors. The situation is not aided because as was stipulated the defendant claimed he explained to his patient the nature of his treatment before administering it. *The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment.*"[10] (Italics ours)

Osteopathy and Its Limitations

Osteopathy is frequently defined as a form of "manual treatment of disease." It is a system of therapy without the use of drugs, based on the theory that diseases are due chiefly to mechanical derangements in the structure of the human body.[11]

Under the accepted principle that osteopaths are licensed to practice only "osteopathy and surgery" and not "medicine and surgery," the Attorney

General has issued numerous opinions confining the practice of osteopathy to its own system or philosophy of treating the sick.[12] Thus it has been ruled by the Attorney General that an osteopath cannot prescribe medicines except those necessary as a part of an actual surgical operation.[13]

Persons licensed to practice osteopathy and surgery may not enlarge the legal scope of their activities merely by undertaking to perform functions properly belonging to the practice of medicine alone. Since vaccination, and the use of serums, antitoxins and the like is a form of preventive medicine, an osteopath is forbidden their use in his practice, for, according to the Attorney General, the "point is that if an osteopath is qualified to practice medicine, he may become licensed to do so."[14]

It follows from this line of reasoning that osteopaths, not being licensed to practice medicine, cannot give the "medical examinations" required in cases of admission to state sanatoria and county tuberculosis hospitals,[15] nor can an osteopath certify to the Wassermann examination as required under the Wisconsin marriage laws.[16] Under a recent opinion of the Attorney General, osteopaths may not give injections for arthritis, although they may administer rectal anesthetic, if licensed in surgery, in connection with an operation.[17]

REFERENCES

1. 21 Atty. Gen. 646, 651, followed by Attorney General in opinion dated October 16, 1940.
2. Advertisement of Wisconsin Chiropractic Association, Appleton Post-Crescent, October 6, 1931.
3. Statement of B. J. Palmer, of Davenport, Iowa, founder of chiropractic, to the Attorney General of Wisconsin, September 6, 1932.
4. Corsten v. Industrial Comm., 207 Wis. 147, 148.
5. 21 Atty. Gen. 646.
6. Op. Atty. Gen. 10/16/40
7. 7 Atty. Gen. 68; 14 Atty. Gen. 442.
8. 17 Atty. Gen. 318.
9. 16 Atty. Gen. 95.
10. State v. Michaels, 226 Wis. 574, 579.
11. Herzog, Medical Jurisprudence, sec. 121, and 29 Atty. Gen. 148.
12. 10 Atty. Gen. 837; 29 Atty. Gen. 148.
13. 14 Atty Gen. 231; 18 Atty. Gen. 6; 19 Atty. Gen. 594; 21 Atty. Gen. 137; 163.
14. 29 Atty. Gen. 148, 153.
15. Chapter 50, Wis. Stats. 1939.
16. Sec. 245.10, Wis. Stats. 1939.
17. Op. Atty. Gen. 10/16/40.

Laws and Rulings Governing Medical Licensure

FOR a complete statement of the laws on "Treating the Sick" physicians are referred to Dr. Harold W. Shutter, Secretary of the State Board of Medical Examiners, 425 E. Wisconsin Avenue, Milwaukee, from whom they may obtain a complete reprint of the then current applicable statutes and rulings of the Board.

In general, all desiring to treat the sick must first secure a certificate of registration from the State Board of Examiners in the Basic Sciences prior to making application for license to practice from their own licensing board. This certificate may be obtained either by examination or by reciprocity where an applicant presents sufficient and satisfactory evidence of having passed examinations in the basic sciences before a legal examining board or officer of another state, or of a foreign country, if the standards are as high as those of this state.

Licenses to practice medicine and surgery are obtained by reciprocity or examination from the State Board of Medical Examiners. Applicants are advised to secure a copy of regulations from the secretary of the State Board of Medical Examiners for complete information and requirements. *Under no conditions, however, will the board grant temporary permits to practice.* Once a license is granted to practice medicine and surgery, it must be recorded, under a law passed by the 1939 session of the legislature, only with the county clerk of the county in which the practitioner resides. Failure to record the license as provided in the statutes prohibits the practitioner from collecting by law any compensation for professional services or from testifying in a professional capacity.

Special sections of the statutes are devoted to the registration or licensure of optometrists, dentists, dental hygienists, nurses, chiropractors, midwives, cosmeticians, chiropodists, and masseurs. But only applicants to practice medicine and surgery, or osteopathy and surgery, are licensed by the State Board of Medical Examiners, and only chiropodists, masseurs, and midwives are registered by that board.

The statutes provide that no person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, shall use or assume the title "doctor," or append to his name the words or letters "doctor," "Dr.," "specialist," "M.D.," "D.O.," or "any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick." This law was held, in a recent opinion of the Wisconsin Supreme Court, to prevent the use of the title by chiropractors (see "Chiropractors and use of title 'Dr.'" in the article immediately preceding) and, in the opinion of the Attorney General, excludes the use of that title by optometrists or those in the field of treating the sick other than physicians and surgeons, or osteopaths.

Physicians desiring to be licensed by reciprocity under the laws of states other than Wisconsin, must furnish to its medical licensure board certain certificates and verified copies of Wisconsin records. Frequently the requirements include copies of examination records in Wisconsin. Where physicians request such records of the Wisconsin State Board of Medical Examiners, the request must be accompanied by a $10 fee.

Coroners; Their Duties and Functions

A COMPLETE discussion of the powers and duties of the coroner would necessitate covering as well the powers and duties of the sheriff, or constable, for in the event that a sheriff or his deputy, for one of several reasons, is prevented from performing the duties of that office, the responsibility becomes that of the coroner. Since only in rare instances does such a situation arise, and since such powers and duties bear little or no relation to matters pertaining to physicians, this discussion is limited to the more familiar and specific powers and duties prescribed by the laws.

Section 59.34, of the Wisconsin Statutes, provides that the coroner shall—

> "take inquest of the dead when required by law" (Subsec. 1) and
> "perform all other duties required by law" (Subsec. 4).

The most important duty, of course, is that relating to inquests, the details of which are set forth in chapter 366 of the Wisconsin Statutes. The legislature has deemed it advisable to leave with the coroner a wide range of discretion.

Section 366.01 provides that when, from the circumstances surrounding the death of any person, the district attorney shall have good reason to believe that murder or manslaughter has been committed, he shall order and require the coroner or his deputy to take "an inquest on the view of the dead body of such person." The statute, however, also gives the coroner, on his own initiative, the power to hold an inquest. The function remains substantially as it has for several centuries. The inquest must be held in the county where the wrongful act or accident occurred regardless of the fact that the resulting death took place in another county.

The coroner's source of information of the death of a person is, of course, varied. Everyone, including a practitioner, owes a duty to report a death to proper authorities when circumstances indicate that a homicide or manslaughter may be involved. A physician, presumably, would be in a better position to draw such conclusions than would a layman; and where the practitioner attends a death involving suspicious circumstances, he would do well to notify the coroner or the sheriff's office.

Inquests

The coroner's first duty, upon being notified of a death, in absence of any request by the District Attorney to hold an inquest, is to determine whether or not in his opinion the facts warrant or require the holding of an inquest. This duty is purely discretionary; the only limitation, presumably, being that which relates to the District Attorney, that is whether there is good reason to believe that murder or manslaughter has been committed. It is impossible to lay down any rules for use in determining when good reason exists. Whether or not the coroner acts will, of course, depend on a number of facts: the objective circumstances of the case, incidental information available to the coroner, and, not to be overlooked, the coroner's own conception of the duties of his office.

Having concluded that the circumstances warrant or demand the taking of an inquest, the coroner's next step is to issue a so-called precept or order to the sheriff or constable to "summon a jury of six good and lawful men of the county to appear before him at the time and place specified in the precept." (In this connection it is pointed out that the power to hold an inquest is an absolute one and should the body have been buried, the coroner or his deputy can compel such body to be exhumed for the purpose of complying with the provisions of chapter 366, provided an inquest has been ordered.) The form of the order compelling the summoning of a jury is prescribed by the statutes. No time limitation is provided for setting the date of the inquest, but the desirability of prompt action in inquests is self-evident and it is the coroner's duty to see to it that prompt administration of the laws be accomplished. In addition to the order compelling the attendance of the jurors, the coroner may issue subpoenas of witnesses, included among which might be one or more competent physicians or surgeons, for the purpose of making an examination of the body and testifying as to the result of the same. Thus, in the exercise of his powers and duties the coroner is called upon to perform functions which are in their nature both judicial and medical.

Medical Functions

The most important medical duty is the investigation of deaths in which an element of violence may be suspected. These might include accidental or suicidal deaths, and deaths of persons who have not been attended by a duly licensed practitioner of medicine, when the cause of death appears uncertain. In making an investigation, the first consideration is how far it will be necessary to carry the examination, a matter which requires the exercise of care and good judgment. The coroner's questioning should be careful and searching, but having satisfied himself as to the natural cause of death, he is justified in going no further in his investigation. If, however, the death requires the discovery of facts other than those which may be revealed by questioning and inspection the coroner must be in a position to avail himself of those highly specialized medical services which enter into a postmortem examination. But unless an inquest has been ordered by the District Attorney or himself, or consent has been given

by the next of kin, or cremation has been directed and an autopsy deemed necessary, an autopsy cannot be ordered.

Quasi—Judicial and Other Duties

Having decided on the necessity for an inquest, the coroner's duty immediately becomes one of both an administrative and a judicial character. In Wisconsin, properly speaking, he is not a judicial officer under the state constitution. Atty. Gen. 323. Nevertheless he has the power to exclude the public from inquests whenever he deems that to be desirable. He does the work of a practicing attorney in bringing out the testimony of witnesses, who are not, as a matter of right, entitled to representation by attorney. The statute provides that the jury is to find not only what caused the death, but who was responsible for it. Because of the informality of the procedure, the coroner is in a position to exercise a great influence over the jury even though the jury's findings are not admissible evidence in a subsequent court trial of an apprehended party. See Groeschner v. John Gund Brewing Co. (1921) 173 Wis. 366, at 370. Nevertheless the coroner can frequently be the primary force in bringing a criminal to justice.

Being in charge of the inquest, the coroner, of course, is not in a position to testify as to the cause of death. His medical training, however, would aid him substantially in forming questions to be asked of the medical witnesses called. 1910 Atty. Gen. 578.

In the absence of the holding of an inquest the coroner is in no different position than an individual as far as stating the cause of death is concerned. Section 69.39 of the Wisconsin Statutes, provides, however:

69.39 Coroner's certificate. Any coroner whose duty it is to hold an inquest on the body of any deceased person, and to make the certificate of death required for a burial permit, shall state in his certificate the nature of the disease, or the manner of death, and if from external causes or violence whether "probably" accidental, suicidal or homicidal, as determined by the inquest; and shall, in either case, furnish such information as may be required by the state registrar to classify the death.

A further duty is imposed upon the coroner by Section 366.19, Wisconsin Statutes, which provides in subsection (2):

It shall be the duty of the respective coroners of this state, in any case where the body is to be cremated, to view and make a careful personal inquiry into the cause and manner of death, and conduct an autopsy or order the conducting of an autopsy, if in their opinion it is necessary to determine the cause and manner of death, and thereupon certify that no further examination or judicial inquiry concerning the same is necessary, if so satisfied, otherwise, or in the event of doubt to proceed as otherwise provided by law.

Accordingly, a coroner may be justified in conducting an autopsy should he be so qualified; if not, then he may call in a licensed physician to conduct the autopsy. It should be kept in mind, however, that only where a coroner has formally ordered an inquest or where the body of the deceased is about to be cremated, is a coroner justified in having an autopsy performed, and in view of the decision of the Wisconsin Court in the case of Koerber v. Patek 123 Wis. 453, a physician should take care that the autopsy he performs is done in connection with a formal inquest or by order of the coroner prior to cremation.

"27.7"

Back in 1904, the leaders in the medical profession of this country—exemplified by such men as Osler, Trudeau, Welch, Klebs, Janeway, Billings, Ravenel, and many others—realized that if tuberculosis, the then "Captain of the men of death," was to be brought under control, an organized plan of combating this most deadly disease must be developed. The result was the National Association for the Study and Prevention of Tuberculosis, today known as the National Tuberculosis Association. In view of the high incidence of this disease, its high mortality, its communicability, and because of the prevalence of many false ideas concerning tuberculosis, it was felt that the most urgent need to bring this disease under control was the education of the lay public in all matters relating to the disease.

While, in a general way, it may be said that the chief function of the National Tuberculosis Association and its affiliated state organizations is the education of the lay public, close cooperation with the medical profession in all its activities has always been a primary and fundamental consideration. No doubt the fact that the leadership in this fight against tuberculosis has been in the hands of the medical profession accounts to a large degree for the splendid relations that have existed for the past thirty-five years between the National Tuberculosis Association, its affiliated state associations, and the medical profession. Here, in Wisconsin, we have been exceptionally fortunate in this harmonious relationship. While at times differences of opinion as to ways and means may have arisen, at no time have these differences taken on a serious aspect.

The aim of the Wisconsin Anti-Tuberculosis Association has evermore been to teach the lay public how to avoid and prevent the development of tuberculosis and to assist the medical profession in raising the standards of tuberculosis diagnosis, care, and treatment to the highest degree.

If the old saying that "The proof of the pudding is in the eating" is true, the medical profession of Wisconsin may well point with pride to the very low tuberculosis death rate—27.7 per 100,000 population. Only eight states in the U. S. can boast of a lower record and of these, seven are sparsely settled states west of the Mississippi River.

The W. A. T. A. desires to take this opportunity to congratulate the medical profession of Wisconsin for the splendid record in the matter of tuberculosis control, for, after all is said and done, the general practitioner of medicine is still the first line of defense in the eradication of this disease. Without the rank and file of the medical profession we would be helpless. The W. A. T. A. also desires to thank the members of the medical profession for the support which it has given, and continues to give, the tuberculosis Christmas Seal, funds from the sale of which finance the work of the organization.

At the same time, the W. A. T. A. wants the medical profession to know that it stands ever ready to be of assistance to all physicians in any matter concerning tuberculosis wherever and whenever the occasion arises.

Oscar Lotz, M. D.,
Executive Secy., W. A. T. A., Milwaukee.

Sterilization

IN 1932, and again in 1938, opinions from the office of the Attorney General indicated the belief of that office that sterilization operations, except in the course of strictly therapeutic surgery, would be held illegal by the Wisconsin courts. Because of the importance of those opinions, they are printed here in full.

The first of the two opinions was rendered to the district attorney of Washburn county, Wisconsin, by Deputy Attorney General Fred M. Wylie in 1932, and is printed in XXI Opinions Attorney General 940, as follows:

"You ask opinion upon the following:

We have advised the county judge and the county children's welfare board that section 46.12 does not prohibit a sane person over twenty-one years of age from being sterilized, if he or she so wishes. We find no other section in the statute pertaining to sterilization. Please advise if our opinion was correct. Is a doctor protected in sterilizing persons who appear there voluntarily?

Is it possible for a county to pay for sterilizing indigents who are now receiving county aid and who voluntarily offer themselves for sterilization?

"In Moore v. State, 3 Pin. 373, it was held that injury to the internal sexual organs of a female was within the mayhem statute, sec. 340.35, the court saying, p. 375:

* * * Nor can we see a reason to support the query made, that "it is extremely doubtful whether an indictment will lie under our statute for disabling an internal organ of the body, like the uterus in a female."

Our legislature certainly gave the same protection to the internal organs of the female that it did to the external organs of the male, and there is no reason why it should not.

"'Malicious intent' as used in sec. 340.35, Stats., relates to a wrongful act intentionally done without just cause or excuse. Keith v. State, (Texas) 232 S. W. 321, 16 A. L. R. 949. Where the act is intentional the establishment of a motive is not necessary. Cupps v. State, 120 Wis. 405, Manna v. State, 179 Wis. 384.

"Opinion was given by the attorney general, XVII Op. Atty. Gen. 524, to the effect that an incompetent person could not be legally sterilized except under sec. 46.12.

"Offhand, it is likely to appear that a competent adult may legally consent to be sterilized, not merely as a curative or preventive therapeutic, but solely to prevent procreation. I do not say that he or she may not, but there is sufficient contra indication in the law and in the disclosed attitude of some judges, to cause one to advise physicians that it is unwise for them to perform such an operation for sterilization purposes alone.

"The question, in its present day application, is new, but it perhaps has its analogies in the common law, which is our law still, in the absence of constitution or statute on the subject. Analogous questions under the common law apparently have not been matters of recent litigation, and we must, perforce, go back into the musty volumes of the common law of early America and earlier England. Here is some of what we find (Italics mine):

"Blackstone, Book IV, Chap. XIV, part III:

And also the law of England wisely and religiously considers, that no man hath a power to destroy life, but by commission from God, the author of it: and as the suicide is guilty of a double offence; one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the King, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes, making it a peculiar species of felony, a felony committed on one's self.

"Blackstone, Book IV, ch. XV, part I, and notes thereto (Cooley's, p. 1370):

For mayhem is properly defined to be, as we may remember, the violently depriving another of the use of such of his members as may render him the less able in fighting * * * So that, by the common law, as it for a long time stood, mayhem was only punishable with fine and imprisonment; unless perhaps the offence of *mayhem by castration,* which all our old writers held to be felony. * * *

Note (c), ibid:

But if the complaint be preferred against a woman that she had *mutilated a man,* she shall be adjudged to lose her hand, as the member with which she had offended.

Note (h): Sir Edward Coke (3 Inst. 62) has transcribed a record of Henry the Third's time (Claus. 13 Hen. III, m. 9), by which a gentleman of Somersetshire and his wife appear to have been apprehended and committed to prison, being *indicted for thus dealing with John, the monk,* who was caught in adultery with the wife.

"1. Hawkins Pleas of the Crown (1824), 107–108:

It seems, that such a hurt of any part of a man's body whereby he is rendered less able, in fighting, either to defend himself or to annoy his adversary, is properly a maim.

And therefore, the cutting off or disabling or weakening a man's finger or striking out his eye or foretooth, *or castrating him,* are said to be maims * * *.

It is to be observed, that all maim is felony. It is said, that *anciently castration was punished with death,* and other maims with the loss of member for member. But afterwards, no maim was punished in any case with the loss of life or member, but only with fine and imprisonment.

By the common law also, *if a person maim himself,* in order to have a more specious pretence for asking charity, or to prevent his being impressed as a sailor, or inlisted as a soldier, *he may be indicted,* and, on conviction, fined and imprisoned.

"Cases are cited to all paragraphs.

"Stephen, Digest of the Criminal Law, 6th ed., arts. 225, 227, 228 (London, 1904):

225. Everyone has a right to consent to the infliction of any bodily injury in the nature of a sur-

gical operation upon himself or upon any child under his care, and too young to exercise a reasonable discretion in such a matter * * *. Note: I know of no authority for these propositions, but I apprehend they require none. The existence of surgery as a profession assumes their truth.

227. Every one has a right to consent to the infliction upon himself of bodily harm not amounting to a maim. A maim is bodily harm whereby a man is deprived of the use of any member of his body or of any sense which he can use in fighting, or by the loss of which he is generally and permanently weakened, * * *. *Castration is a maim.* Note: The positive part of this Article is proved thus:—Injuries short of maims are not criminal at common law unless they are assaults, but an assault is inconsistent with consent. As to the definition of a maim, see 1 Hawk. P.C. 107. *He expressly mentions castration.*

228. *No one has a right to consent to the* infliction upon himself of death, or of an injury likely to cause death, in any case (other than those mentioned in Article 225), or *to consent to the infliction upon himself of bodily harm amounting to a maim,* for any purpose injurious to the public.

Illustrations: (1) A and B agree to fight a duel together with deadly weapons. If either is killed or wounded his consent is immaterial. (2) A *gets* B *to cut off* A's *right hand,* in order that A may avoid labour and be enabled to beg. *Both* A *and* B *commit an offence.*

"People v. Clough, (1837) 17 Wend. 351–352:

In 2 Russell on Crimes, 289, a case is put, which the writer represents as a curious species of indictable fraud, viz. that of a man who maimed himself in order to have a more specious pretence for asking charity, and Coke, Hale and Hawkins are referred to. This led me to examine the authors alluded to, and I find that none of them put the case on the *fraud,* but on the *mayhem,* and accordingly treat it under the title "maiming." They all go on the case statute by Lord Coke, who says: "In my circuit in anno I Jacobi Regis, in the county of Liecester, one Wright, a young, strong and lusty rogue, to make himself impotent, thereby to have the more color to begge or to be relieved, without putting himself to any labour, caused his companion to strike off his left hand, and both of them were indicted, fined and ransomed therefore; and that by the opinion of the rest of the justices for the cause aforesaid: Co. Lit. 127, a. This and other cases were introduced by Lord Coke, with the observation, "Note, the life and members of every subject are under the safeguard and protection of the King." So that the indictment was clearly not for the fraud.

"Bishop, Statutory Crimes, sec. 744:

* * * Some have denied that, if she consents, it is indictable at the common law, unless she has arrived at the state of pregnancy termed quick with child. [Com. v. Parker, 9 Met. 263; Com. v. Bangs, 9 Mass. 387; S. v. Cooper, 2 Zab, 52; Smith v. S., 33 Me. 48.] And Hale has on this subject the expression "quick or great with child;" and Coke, "quick with child;" but not in connections denying that the offense may be committed at an earlier stage of the pregnancy. Others reject this distinction. "It is not," said Coulter, J., delivering the opinion of the Pennsylvania Court, "the murder of a living child which constitutes the offense, but the destruction of gestation by wicked means and against nature. The moment the womb is instinct with embryo life, and gestation has begun, the crime may be perpetrated." [Mills v. Com., 13 Pa. St. 631, 633; followed by the North Carolina tribunal in S. v. Slagle, 83 N.C. 630, 632; Taylor v. S., 105 Ga. 846, 33 S.E. R. 190.] This, in principle, seems to be the reasonable and just doctrine.

"Wharton's Criminal Law, 11th ed., secs. 182, 183, 767:

182. Any injury committed in such way as to be an offense to the body politic can be prosecuted in defiance of the consent of the party immediately injured. Prize fighters, for instance, may agree to beat each other, and if this is done in private, and death or mayhem does not ensue, no prosecution lies at each other's instance, but it is otherwise when there is a breach of the peace; or when the fighting is so conspicuously brutal as to produce public scandal, or work public demoralization. *Consent cannot cure* duels or incest or seduction or adultery or the *maiming of another so as to render him unfit for public service, or such operation on women as prevent them from having children,* or operations to produce miscarriage, or (when this is by statute indictable) profligate dealings with minors. The reason is that parties cannot by consent cancel a public law necessary to the safety and morality of the State.

183. * * * Inalienable rights are thus generally defined as life, liberty, and the pursuit of happiness. * * *

184. Life is the first of these inalienable prerogatives. Thus, a man who kills another with the latter's consent is guilty of homicide. * * * We may, therefore, justly argue that if life be an inalienable prerogative, then taking it by self is a public wrong, and those who are accessories to this public wrong can not plead in defense the suicide's consent.

As will hereafter be more fully illustrated, consent will authorize a surgical operation in cases of danger, though the effect of such operation may be fatal.

767. Consent of the party injured is no defense to an indictment for mayhem.

"Wharton's Criminal Law, 11th ed., sec. 19. Absence of common law precedent does not preclude a common law indictment in this country:

"Sec. 23, ibid:

* * * It has been held indictable to cast a dead body into a river without the rites of Christian sepulture; to be guilty of eavesdropping; to knowingly sell noxious food; to sell a wife; to disinter a dead body without proper authority; to give more than a single vote at an election; to be guilty of individual offensive drunkenness, or notorious lewdness, though on this point the better rule is that, to make the offense indictable, it must be such as to shock and insult, not an individual, but the community; to indulge publicly in profane swearing, or in foul and obscene language; so as to draw together a crowd in a thoroughfare, though the offense be not laid as a nuisance; and, in fine, to commit any act which from its nature must scandalously affect the moral and health of the community.

"The foregoing contains abundant (sic) (and more of the same kind is available) for anti-minded judges to hold that sterilization, even by modern vasectomy or salpingectomy and of a competent adult consenting thereto, violates unchanged common law, or our present mayhem statute, which is largely word for word the Coventry Act, 22–23 Caroline II, c. 1. Sterilization has not been received by the courts with any open-armed welcome. Against the opposition of those of the public and on the courts

who consider such interference with nature to be immoral or sinful, legislatures have so far made no great strides, and a great deal of what has gotten past the opposition in legislatures, has succumbed in courts. See the following:

State v. Feilen,—Wash. —, 126 Pac. 75, 41 L.R.A. (N.S.) 418
Davis v. Berry, 216 Fed. 413
Smith v. Examiners, 85 N.J.L. 46, 88 Atl. 963
Osborn v. Thomson, 103 Misc. 23, 169 N.Y. Supp. 638
Haynes v. Williams, 201 Mich. 138, 166 N.W. 938, L.R.A., 1918 D. 233
Smith v. Command, 231 Mich. 409, 204 N.W. 140, A.L.R. 515
In re Salloum (Mich.), 210 N.W. 498

"These are all cases of involuntary sterilization of incompetents and criminals, but they disclose the attitude of mind of the judges. In Michigan, the sterilization statute was finally sustained by a three to four decision. The majority and minority opinions (Smith v. Command, supra) exhibit little difference in understanding of law, but such opposite understanding of the subject matter as to make the same law have opposite consequences.

"Even if we assume that the scientific and sociological view should prevail, nevertheless the law follows science, in some fields by perhaps a generation, for the law can reflect the advances of sciences only when they have been accepted by the people generally. Science may have a duty to educate the law, but it has no duty to defy it, nor to take a serious chance with it. The consequences to a physician from the performance of an operation of this kind, should the courts hold it illegal, could be serious. Until the law is settled, it is not prudent for a physician to perform a sterilizing operation except within the ancient field of surgery, viz., when it is a therapeutic measure.

"And if the poor relief officials should, as you suggest in your letter, become parties to the performance of such an operation, they, as well as the physician, would be liable to the penalties of the criminal law in case the courts should follow the letter of the old common law and hold that change in the application thereof can be only by legislative action.

"It is not my intention in this opinion to take any position upon the religious and sociological phase of the question. It is my personal and official opinion, however, that the legal question is better to be settled in the legislature than in the courts with some well-intentioned public official or physician as the potential victim."

The second of the two opinions was written by Assistant Attorney General Warren H. Resh in 1938, and is printed in XXVII Opinions Attorney General 416. It was rendered to the district attorney of Vilas county, Wisconsin, and follows in full:

"You ask whether a vasectomy 'can be performed safely' where the patient is willing to consent in writing and where it is the opinion of several examining physicians that the operation would benefit the patient's health. The man is not confined in an institution as a criminal, insane, feeble-minded or epileptic person and therefore sec. 46.12, Stats., relating to sterilization does not apply. No doubt you have in mind the mayhem statute, sec. 340.35, and the question is whether this statute would forbid sterilization in the present circumstances.

"So far as is applicable, the section reads:

> Any person with malicious intent to maim or disfigure, who shall * * * cut or disable a limb or member of another person, and any person privy to such intent who shall be present aiding in the commission of such offense shall be punished by imprisonment in the state prison, not more than fifteen years nor less than one year, or by fine not exceeding five thousand dollars nor less than two hundred dollars.

"The sex organs are 'members' of the person within the meaning of the statute. Moore v. State, 3 Pin. 373 (1851). As vasectomy involves a disability to procreate, one performing such an operation would bring himself within the terms of the statute, if possessed of a malicious intent to maim or disfigure. 'Maim' has no technical meaning. State v. Foster, 281 Mo. 618, 220 S. W. 958; Commonwealth v. Newell, 7 Mass. 245. As used in sec. 340.35, Stats., it is sufficiently broad to include the infliction of almost any disability.

"A malicious intent does not necessarily involve malice toward the particular individual. 40 C. J. 3. So-called 'legal malice' is sufficient. Construing a statute practically identical to ours (U. S. Rev. Stats. 1873, sec. 5348), the court said in United States v. Gunther, 5 Dak. 234, 38 N. W. 79, 80–81:

> * * * The word "maliciously" * * * means nothing more than that the act should be done voluntarily, intentionally, unlawfully, and without excuse or justification, * * *.

"To the same effect, see Bowers v. State, 24 Tex. App. 542, 7 S. W. 247, and State v. Compton, 77 Wis. 460, 466.

"From an act done voluntarily and against the terms of the statute malice is implied unless the circumstances of the particular case are such as to justify or excuse the act, for such justification or excuse negatives the presence of malice.

"Mere consent of the patient is not sufficient excuse to negative malice, however. For while certain crimes, such as larceny and rape, require that the act be done against the will, in others, such as homicide and mayhem, consent of the victim is no defense. See I Bishop on Criminal Law, 9th ed., sec. 259 and cases cited; Coke, on Littleton, 127, a. The only purpose of obtaining consent is to foreclose civil liability. See Bishop, *opere citato*, sec. 256; but compare Miller v. Bayer, 94 Wis. 123 (1896).

"The only case involving voluntary sterilization which has come to our attention is Christensen v. Thornby, (Minn.) 255 N. W. 620, a case notable in that the plaintiff sued on a theory of breach of warranty in that the operation did not have the desired effect, and he sought to measure his damages by the expense of a subsequent and unexpected childbirth. The court held that the contract was not void as against public policy, since it was thought to be necessary to save the life of the plaintiff's wife.

"It is said by Bishop in sec. 346 of the work cited that the law of necessity is supreme and that all law has in it this implied exception. Stephen writes to the same effect in his Digest of the Criminal Law, art. 33, but points out that the limits of the doctrine are vague. Each case in which the doctrine is invoked would necessarily have to stand on its own particular set of facts.

"In this regard necessity to save life and necessity to preserve health should stand on an equal footing, because of the difficulty of telling in some cases where one stops and the other begins. It is only because justified by the necessity to preserve health that a dentist who pulls an ailing incisor does not commit mayhem under the broad terms of the statute. Likewise with the physician.

"We conclude that vasectomy in the instant case may be excusable by reason of necessity to preserve health. For a more complete discussion of the subject we refer you to Miller and Dean's article in 16 Am. Bar Ass'n Journal 158 (1930). See also XXI Op. Atty. Gen. 940."

Care of the Illegitimate Child*

WISCONSIN statutes relating to the care of the child born out of wedlock place the responsibility for the care, protection, and education of these children on the State Department of Public Welfare. Chapter 46.03 (11) (12) of the Wisconsin statutes provide:

46.03 **General functions of the board.**

(11) The board shall promote the enforcement of all laws for the protection of mentally defective, illegitimate, dependent, neglected and delinquent children, except laws whose administration is expressly vested in some other state department. To this end it shall co-operate with juvenile courts and all licensed child welfare agencies and institutions of a public or private character, and shall take the initiative in all matters involving the interests of such children where adequate provision therefor has not already been made or is not likely to be made.

(12) When notified of the birth or expected birth of an illegitimate child, the board shall, through advice and assistance of the mother, or, if necessary, independently of the mother, see to it that the interests of such child are safeguarded, that appropriate steps are taken to attempt to establish the paternity and that there is secured for him the nearest possible approximation to the care, support and education that he would be entitled to if born of lawful wedlock.

The Department of Public Welfare has delegated responsibility for this matter to its Division of Child Welfare. There is a limited field staff in this division and the cases are therefore assigned to licensed child welfare agencies and children's workers depending upon the age, religion and legal settlement of the mother. The licensed agencies giving service in this type of case are:

The Children's Aid Society of Wisconsin
2835 W. Kilbourn Avenue
Milwaukee, Wisconsin

The Children's Service Association
734 North Jefferson Street
Milwaukee, Wisconsin

The Lutheran Welfare Society
3005 West Kilbourn Avenue
Milwaukee, Wisconsin

Evangelical Lutheran Kinderfreund Society
8138 Harwood Avenue
Wauwatosa, Wisconsin

Green Bay Diocese Apostolate (Catholic)
131 South Madison Street
Green Bay, Wisconsin

Catholic Child Welfare Bureau
3222 South Avenue
La Crosse, Wisconsin

Catholic Social Welfare Bureau
625 N. Milwaukee Street
Milwaukee, Wisconsin

Jewish Social Service Association
2218 North Third Street
Milwaukee, Wisconsin

Maternity Homes

If an unmarried, expectant mother requests the assistance of a physician in making confinement plans or plans for the child, it is advisable to communicate with the Division of Child Welfare, State Department of Public Welfare, Room 32S, State Capitol, Madison. Confinement care is often arranged at one of the several maternity homes in the state where only unmarried girls are admitted. These homes are:

Salvation Army Maternity Home
6306 Cedar Street
Wauwatosa, Wisconsin

Misericordia Hospital
2224 West Juneau Street
Milwaukee, Wisconsin

The Summit Hospital
Oconomowoc, Wisconsin

St. Ann's Hospital
1020 Market Street
La Crosse, Wisconsin

* Prepared for The Journal by Miss Dorothy Waite, Division of Child Welfare, State Department of Public Welfare, State Capitol, Madison.

St. Mary's Mothers' and Infants' Home
403 Webster Avenue
Green Bay, Wisconsin

Admission to these hospitals may be arranged by writing directly to the superintendent of the hospital or to the Division of Child Welfare. All hospitals require a negative smear, Wassermann and throat culture before the patient is admitted. These hospitals admit Protestant or Catholic girls and the fee is $50 which includes care during confinement and three months after the birth of the child. The only exception to this is St. Ann's at La Crosse which admits only Catholic girls and charges a slightly higher fee. At these hospitals the girls are given some duties which contribute to the care received. At Summit Hospital the girls may remain long enough to work out their entire bill.

Many girls do not want the group life which exists in maternity homes, and care in private family homes is often the best solution. Many private homes are willing to take a girl and keep her until confinement is needed, at which time the girl enters the hospital. This type of care is slightly higher in cost, averaging about $5 per week in the private home, and $50 to $60 for ten days' hospital care and the services of a physician. Any of the licensed agencies or the State Division of Child Welfare can give addresses of private homes where this kind of care can be arranged.

A three months' nursing period was at one time required, but after careful study by the agencies and the Division of Child Welfare regarding the relative value of breast feeding and artificial feeding, the Board of Public Welfare adopted the following policies in 1938:

Every child shall be required to be breast fed for a time to be determined by the attending physician unless it be not for the physical well being of the child or mother, or unless there exist other conditions which make such feeding impractical. In such exceptional cases properly supervised artificial feeding may be authorized.

This permits the agency to make separate plans for the child in a licensed foster home until the child can go to a permanent home.

Plans for the Child

Plans for the child in each case vary with the individual needs of the mother and child:

(1) If the mother wishes to keep her child with her and assistance from the father has not been possible, she is eligible for aid to dependent children through social security funds in the event that her own family is not able to give financial assistance.

(2) The child may be cared for in a temporary foster home pending the mother's decision to make permanent plans to keep the child either with herself or in an adoptive home.

(3) Adoptive placement may be made if the background and history of the child show that he is a suitable subject for adoption. The licensed agencies mentioned above are licensed to place children in adoptive homes. The advantage of this plan is that the mother and the adoptive parents do not know each other, and that the plan is worked out slowly and carefully so that the mother is not rushed into a decision of this kind and is less likely to change her mind.

(4) The mother may marry the father of her child. When this is done the birth may be legitimized and the record is similar to that of any child born in wedlock.*

The laws regulating the placement of children place definite restrictions on any person or agency not licensed to perform this function. It is advisable for a physician immediately to refer any prospective adoptive couple or unmarried mother who wishes to release her child to the Division of Child Welfare or to one of the licensed child welfare agencies mentioned above in order to avoid violating the law.

The statutes read as follows:

48.37 **Licenses; records; reports.** (1) No person, other than the parent or legal guardian, and no firm, association or corporation, and no private institution shall place, assist, or arrange for the placement of any child in the control and care of any person, with or without contract or agreement, or place such child for adoption, other than a licensed child welfare agency.

48.40 **Violations.** (1) Whenever the state board of control† shall be advised or shall have reason to believe that any person, firm, corporation, association or private institution, is conducting or acting as a child welfare agency in this state without being licensed as in this chapter provided, or is in any way, directly or indirectly, offering to place any child or holding himself or itself out as being able to place or dispose of children in any manner, it shall make an investigation to ascertain the facts. If it finds that such person, firm, corporation, association or private institution is so acting without a license, it may either issue a license upon application therefor, or may cause a prosecution to be instituted under the provisions of section 48.41.

48.41 **Penalties.** (1) Any person who shall act as a child welfare agency without a license as provided in this chapter or who shall violate any of the provisions of the statutes relating to the organization, conduct and operations of child welfare agencies, or who in any way, directly or indirectly, offers to place or dispose of any child or hold himself out as being able to place or dispose of children in any manner whatsoever, shall upon conviction thereof be punished by a fine of not less than ten nor more than five hundred dollars or by imprisonment in the county jail for not more than one year, and said term of imprisonment in case of an association or a corporation may be imposed upon its officers who participated in said violation.

Further information in regard to the above matters may be obtained by writing to the Division of Child Welfare, State Capitol, Madison.

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* See page 1087 for information in regard to correction and legitimation of the birth record.

† Revisor's note. The state board of control was abolished and the functions thereof transferred to the state department of public welfare by chapter 435, laws of 1939.

Fee Splitting

BY STATUTE enacted in 1913, and strengthened in 1915, fee splitting by physicians is prohibited, even between physicians taking part in the same operation. Each physician must render his bill direct to the patient. Because of the importance of this subject, the fee splitting statute and opinions with respect to it are discussed here in detail.

Section 343.322 of the Wisconsin Statutes provides:

Fee splitting by physicians. (1) Any physician or surgeon who shall claim or demand and collect and receive any money or other thing of value as compensation for his professional services in treating or operating upon a patient who was induced or advised by another physician or surgeon to submit to such treatment or operation, and who shall have previously paid or delivered, or shall thereafter pay or deliver, any money or other consideration to such other physician or surgeon or his agent, as compensation for such inducement or advice, or as compensation for assistance in the case, or any physician or surgeon, giving such inducement or advice, who shall, as compensation therefor, or as compensation for assistance in the case, demand, receive or retain any money or other consideration directly or indirectly from the physician or surgeon treating or operating upon the patient so induced or advised, shall be guilty of a criminal fraud and upon a conviction thereof shall be punished by a fine of not more than one hundred dollars or by imprisonment in the county jail not exceeding six months. Such conviction shall operate also as an annulment of the license held by the convicted person to practice as such physician or surgeon.

(2) Any physician or surgeon, not a citizen of Wisconsin, who shall in any adjoining state treat or operate upon a citizen of Wisconsin, and who shall have previously paid or delivered, or shall thereafter pay or deliver, any money or other thing of value to another physician or surgeon as compensation for inducing or advising such patient to submit to such treatment or operation, or as compensation for assistance in the case, is forbidden to practice medicine or surgery within this state or to participate in this state with other physicians and surgeons in consultations. Every violation of this subsection shall be a misdemeanor punishable by a fine or by imprisonment as prescribed in subsection (1).

(3) Any physician, surgeon, nurse, anesthetist, or medical assistant or any medical or surgical firm or corporation who shall render any medical or surgical service or assistance whatever or give any medical, surgical or any similar advice or assistance whatever to any patient for which a charge is made from such patient receiving any such service, advice or assistance, shall render an individual statement or account of his charges therefor directly to such patient, distinct and separate from any statement or account by any other person, firm or corporation having rendered or who may render any medical, surgical or any similar service whatever or who has given or may give any medical, surgical or any similar advice or assistance to such patient. Any violation of this provision shall be punishable by the penalty prescribed in subsection (1) of this section.

(4) All prosecutions under this section shall be in the circuit court.

Opinion of Attorney General

Shortly after the passage of this law, Attorney General Walter C. Owen, later a member of the Wisconsin Supreme Court, was called upon to give his opinion with respect to its interpretation and general effect. His opinion, published in III Atty. Gen. 218, is printed here in its entirety:

"In your letter of the 10th you enclose a letter written you by Ed. C. Gottry, attorney, of Reedsburg, in which he asks you to get my opinion upon a number of questions submitted by him upon the proper construction of sec. 4431b, Stats.

"Ordinarily I do not give official advice upon matters that do not come before a district attorney in his official capacity. Where, however, the questions submitted relate to matters of public importance, and call for the construction of a statute that a district attorney is likely to be called upon at any time to enforce, I feel that it is not only proper but my duty to give him such aid as is in my power.

"The first question submitted by Mr. Gottry is:

Under the law as it now stands, can a surgeon, not a member of the regular staff of a hospital operate at such hospital for stated fee for the institution, and let the hospital collect the surgical fee from the patient according to ability to pay with other hospital fees; the hospital paying the surgeon the fee agreed upon whether larger or smaller than the fee charged the patient by the hospital, or must the surgeon under the circumstances, charge the fee for the operation direct to the patient?

"Subsec. 1, sec. 4431b provides:

Any physician or surgeon who shall claim or demand and collect and receive any money or other thing of value as compensation for his professional services in treating or operating upon a patient who was induced or advised by another physician or surgeon to submit to such treatment or operation, and who shall have previously paid or delivered, or shall thereafter pay or deliver, any money or other consideration to such other physician or surgeon or his agent, as compensation for such inducement or advice, or as compensation for assistance in the case, shall be guilty of a criminal fraud and upon a conviction thereof shall be punished, etc.

"The object of this law, as I understand it, was to prevent the practice, which was alleged to have grown up in this state, of physicians and surgeons in the larger cities, paying fees or commissions to the country physicians and surgeons for inducing or advising patients to submit to operations or treatments by such city physicians and surgeons. Such fees or commissions were not for any services rendered to the patient, but purely a service rendered to the other physicians or surgeons in the way of sending them this business. Generally it was not known to the patient that this fee or commission was being paid. It was felt that this was an abuse, as it made it an inducement for the physician or surgeon first consulted to induce or advise the patient to sub-

mit to treatment or operation by the city physician or surgeon offering the largest fee or commission, regardless of his ability or skill. It would seem that it was intended not only to prevent the paying of these fees or commissions, but also to prevent the employment by one physician or surgeon of another, except, possibly, that one physician may employ another upon salary, and not to be paid a separate compensation for each case.

"While the law does not specifically make it an offense for a hospital to employ a surgeon, not a member of its regular staff, to perform a particular operation, the hospital to make its charge to the patient for such operation or treatment, and to make its charge for such service irrespective of the amount paid by it to the surgeon, yet it would seem to me that the evils incident to such a practice would be as great as in the case of fee splitting between two physicians or surgeons. It appears to me that this comes very close to the line, and I certainly should not want to advise any surgeon or hospital that it was not a violation of the law. I realize, however, that it might be a hard matter to secure conviction in such a case, unless it could be shown that some consideration was paid to the physician or surgeon bringing the patient to the hospital, with the knowledge of the physician or surgeon giving the treatment or performing the operation.

"Mr. Gottry's second question is:

Where a surgeon operates at a hospital in which he has a financial interest or in which he is part owner or sole owner but conducts the business in the name of the hospital must he make a separate charge for operation or may the whole charge be made by and in the name of the hospital?

"It would appear to me that the hospital may employ a physician or surgeon upon salary, and then make a contract with the patient to furnish him both medical or surgical treatment and hospital service. If this is done the entire charge could be made in the name of the hospital. If, however, the physician or surgeon is not paid a salary, but charges separately for each treatment or each operation, then, in my opinion, the safer practice is to make the charge direct to the patient and let the hospital make this charge to the patient.

"The third question asked is:

Can a surgeon who is not a resident of the city where the hospital is located and who does not hold himself out as a member of the staff of such hospital operate at such hospital and make a charge direct to the hospital under the existing law?

"The section referred to is a penal one and would be strictly construed. Such strict construction, however, should not be carried to the length of so construing the statute as not to carry out the purpose for which it was enacted. As was said by the court in the case of State v. Oredson, 105 N. W. 188, 96 Minn. 509, in speaking of a law prohibiting the practice of medicine or surgery without a license: 'The act is a beneficial one, and is entitled to a reasonable construction.'

"As stated above I believe the safer practice under such circumstances would be for the surgeon to make the charge direct to the patient.

"Mr. Gottry's fourth question is:

Where a country physician engages a surgeon to assist him in an operation at the home of the patient or at the residence of the country physician can the surgeon make his charge direct to the country physician engaging him or must he make a special contract with the patient?

"Here, too, it would appear to me that the safer practice would be for the surgeon assisting in the operation to make his charge direct to the patient. The statute specifically forbids the surgeon performing the operation to pay the physician or surgeon who induced or advised the patient to submit to the operation any money or other consideration either as compensation for such inducement or advice, or as compensation for assistance in the case. It would appear to me that the same reasoning would apply where the physician or surgeon advising or inducing the operation collects the entire fee and then pays the surgeon performing the operation.

"This would seem to also answer the fifth question asked by Mr. Gottry, which is:

Under conditions named in question 4, can the country physician make the contract with the surgeon or must the contract be made directly with the surgeon by the patient?

"It would seem that the only safe practice is for each physician or surgeon to contract direct with the patient. This would not prevent another physician or surgeon acting as agent of the patient in negotiating such a contract.

"The sixth question is:

Is a physician who brings a patient to a hospital for an operation or to a surgeon for an operation entitled to a fee for assisting in such operation or for time spent in accompanying the patient to the hospital or place of operation?

"In my opinion the physician could make a charge for such services, but such charge should be made direct to the patient and not the surgeon or to the hospital.

"This also answers the seventh question, which is:

If the above question is answered in the affirmative, how can the charge be made and who should present the bill—the local physicians or the surgeon performing the operation?

"The eighth question is:

Can a surgeon make a regular fee for operations to a physician, including fee for operating room, dressings, anaesthetic, etc., say from $5.00 to $100.00 for each case—irrespective of ability of the patient to pay and the physician in charge of the case collect his fee including such operating fee as he thinks right, the surgeon performing the operation doing the work for and on contract with the physician, the same as physicians frequently do work for factories and other employers of labor, charging a regular fee irrespective of ability of patient to pay?

"It appears to me that under this law it is illegal for one physician or surgeon to employ another physician or surgeon to treat a certain patient or per-

form a certain operation. If this is not the case, then the doors are wide open for evasion of the statute. It should be distinctly understood that for the treatment given or operation performed, the patient pays the only compensation that is received by the physician or surgeon giving the treatment or performing the operation, and that he pays no more than is received by such physician or surgeon. No intermediate physician or surgeon should either profit or lose by the services performed by such other physician or surgeon.

"The ninth question is:

If the surgeon or hospital charges a regular fee for operation to physicians, must the same fee be charged to patients who come for operation not accompanied by their physician, or can the surgeon or hospital make a charge suited to the ability of the patient to pay?

"As to the amount that may be charged by a surgeon or hospital, that relates purely to the civil liability of the patient to the hospital or surgeon, and in no way involves a construction of this statute and is not a question upon which I feel it my duty to give you advice. However, as stated above, no part of the fee received by the surgeon or hospital should be paid to the physician or surgeon inducing the patient to take such treatment or submit to such operation. Neither should the hospital charge the patient for such treatment or operation except where the surgeon performing the operation is a regular member of the staff of the hospital, and is compensated by it by a salary. In other cases the charge should be made direct to the patient by the surgeon performing the operation.

"The tenth question is:

If surgeons are permitted to contract with physicians for operations must they also contract for care after the operation, as when the surgeon runs a hospital, or may they charge according to the time patient remains and what services are rendered the patient?

"In my opinion surgeons are not permitted to contract with physicians for operations, and therefore this question does not call for any further answer.

"The eleventh question is:

In the above named case must the charge be made direct to the patient or can the charge be made to the physician who was the regular medical adviser of the patient?

"In my opinion the only safe practice is for the charge to be made direct to the patient.

"The twelfth question is:

Can a hospital make and collect for a surgical operation a fee for use of operating room, dressings, anaesthetic, services of nurses, etc., say from $5.00 to $25.00 for each case, and can attending physician later collect fee for operation when no fee was charged directly to the patient by the operating surgeon?

"I believe this question is answered by what has already been said herein. *Neither physician or surgeon can charge the patient for services performed by the other. Each must make his own contract with the patient.*"

A Subsequent Opinion

In 1935 the statute was again referred to the Attorney General for his interpretation as to its effect under certain circumstances. His opinion, published in XXIV Atty. Gen. 580, follows in full:

"Governor La Follette has forwarded a letter received by him from you under date of July 29, pertaining to the splitting of fees by physicians, and asks us to render an opinion to you on this matter and give a copy of the same to him.

"In your letter to Governor La Follette you state:

"Dr. A sent me a letter that Dr. B had sent him and also a check for $3.50, representing two-thirds of a fee that was paid to Dr. B. Dr. B was the family doctor for a man by the name of C. Dr. B does not perform major operations. After examining this man he diagnosed his illness as, I believe, appendicitis and informed him that he would call in Dr. A to perform the operation. It was satisfactory with his patient. Dr. A. performed the operation. Mr. C. paid Dr. B periodically. Dr. B charged a customary and going charge for the operation. As fast as Dr. B receives his instalments he pays Dr. A two-thirds. Dr. B gave the anaesthetic and assisted Dr. A in the operation.

"You state you have consulted with a judge of a circuit court and that you are satisfied that this law does not intend to apply where the relation of patient and doctor has already existed but is designed to prevent undesirable doctors and lay persons from doing an ambulance chasing business by suggesting, advising and inducing patients to submit to an operation by a certain doctor, who pays the advising or inducing doctor.

"Sec. 343.322, subsec. (1), Stats., was first enacted in ch. 570, Laws 1913. An official opinion on the interpretation of this law was rendered by Justice Owen, then attorney general, on June 15, 1914, found in III Op. Atty. Gen. 218. Twelve questions were submitted to him, which he answers in this opinion and came to the conclusion that the statute was intended to prevent splitting or division of fees by physicians and surgeons and the act was construed as to its effect upon various practices by hospitals, physicians and surgeons.

"The law was strengthened and broadened by ch. 469, Laws 1915. Another section was added by said chapter which is now subsection (3) of said section and subsection (1) was enlarged. . . .

"You will note that Judge Owen already, in the opinion rendered prior to the time when the law was strengthened, held that the physicians must make their charges direct to the patient. The law is now so clear, in my opinion, that there can be no question but that a practice such as you described in

your letter comes clearly within the purview of that law. There is no ground for holding that it does not apply to a case where the relation of patient and doctor had already existed. If that were the case it would be an easy matter to circumvent this statute.

"We are clearly of the opinion that the law was violated in the case described by you. This statute does not prevent more than one physician from taking part and assisting in the operation but it requires that each physician render his bill direct to the patient."

Narcotic Laws

General Statutes and Regulations

THE December, 1939, Blue Book issue of the Wisconsin Medical Journal contained an article written by the U. S. Commissioner of Narcotics, H. J. Anslinger, entitled "The Harrison Narcotic Act, and the Practitioner." This study, reprinted here because it is both authoritative and complete sets forth in detail the provisions of the act and its relation to the practitioner. The Harrison Narcotic Act was technically drafted as a revenue measure, for only through the taxing power can the federal government control or regulate traffic in drugs within the states themselves, but it was primarily intended, as Justice Holmes pointed out in United States v. Jin Fuey Moy, (1916) 241 U. S. 394, to control and regulate the sale and use of narcotics.

The State Law

The federal act, however, because of constitutional limitations on the scope of its operations, was not sufficient. Supplemental state legislation was essential. This need was recognized by the proposal in 1932, by the National Conference of Committees on Uniform State Laws, of a "Uniform Narcotic Drugs Act," and since that time, thirty-nine states, including Wisconsin, have adopted the act; the Wisconsin Law being enacted by chapter 306, in the Laws of 1935 as chapter 161, Wis. Stats.

The state act was intended to facilitate the regulation, control, and enforcement, with particular emphasis on enforcement, of the use of narcotics in conformity with the aims and purposes of the federal act. In drafting the state law, effort was made to avoid any duplicate effort, either on the part of the enforcement officers or the persons subjected to the act. The state law makes specific reference to the federal act and provides that a compliance with the federal law shall constitute a compliance with corresponding sections of the state law. The procedure to be followed by practitioners and others subject to the law, is adequately set forth in the article by Commissioner Anslinger, which follows on page 1067 of this issue; from it the practitioner may obtain the general procedure required of him. Some statutory requirements and penalties relating to the physician's professional use of narcotics and marijuana are summarized for the physician's convenience at the end of this introduction. There are certain additional factors which merit consideration by the practitioner, some of which arose subsequent to the passage of the Wisconsin law, and which, while not specifically falling under the provisions of the Federal Harrison Narcotic Act, are related to the subject in a general way.

Use of Narcotics and the Practitioner

It must be remembered, first of all, that the practitioner can use narcotics only in connection with patients upon whom he is in attendance in the regular course of his professional practice. Except for the provisions of Sec. 161.27, Wisconsin Stats., forbidding the possession and use of opium pipes and Sec. 161.275, as enacted by chapter 49 of the Laws of 1939, outlawing smoking preparations of hemp or loco weed and the use of marijuana in a form suitable for smoking or beverage purposes, neither the state nor federal act places any limitation upon the quantity that may be used, the time during which it may be continued, or the form in which it may be administered.

The courts have, however, definitely held that the administering, dispensing and prescribing of drugs for the sole purpose of satisfying the craving of an addict is not within the limits of professional practice as contemplated by the act. In the use of such drugs the practitioner must always act in good faith. Because of this construction of the act by the courts and the similar position taken by the federal authorities the practitioner should take care to avoid any suspicion of noncompliance, not so much because of possible conviction but because of the trouble and expense and adverse publicity which might result should the practitioner be charged with violation of the act. In consideration of the narcotic law's application, the practitioner should keep in mind the following three phases of the problem: administration, dispensation, and prescription.

1. *Narcotics Administered by Practitioners.*—It is in this branch of the use of narcotics that the practitioner is given the greatest freedom. Under the federal law, he is not compelled to keep a record of the drugs administered either by himself or by his duly authorized assistant, intern or nurse. The state law, however, does require practitioners to maintain a record of any narcotic drugs administered except—

Narcotic drugs administered, dispensed or professionally used in the treatment of any one patient,

where the amount administered, dispensed or professionally used for that purpose does not exceed in any forty-eight consecutive hours, (a) four grains of opium, or (b) one-half of a grain of morphine or of any of its salts, or (c) two grains of codeine, or of any of its salts, or (d) one-fourth of a grain of heroin or of any of its salts, or (e) one grain of extract of cannabis or one grain of any more potent derivative or preparation of cannabis, or (f) a quantity of any other narcotic drug or any combination of narcotic drugs that does not exceed in pharmacologic potency any one of the drugs named above in the quantity stated.

The only standard required is that he administer the drug in good faith, in accordance with accepted professional practice.

2. *Narcotics Dispensed by Practitioner.*—Under both acts, the practitioner is required to keep a record of all narcotic drugs dispensed by him, such record showing the amount, date dispensed, name and address of the patient; this record must be kept for two years. One record will suffice for both federal and state requirements. When the practitioner's office is accessible to the patient, the dispensing of narcotics should be avoided as much as possible; certainly no more should be placed in the hands of patients than is necessary to provide until the next visit.

3. *Prescribing by Practitioner.*—The laws do not compel the practitioner to keep records of the prescriptions issued, but the physician's case records should be complete and in detail. The practitioner should bear in mind that the best professional opinion seems to recognize the fact that an attempt to cure an addict outside the walls of a hospital or other institution is almost certainly doomed to failure and that an attempt to cure under such circumstances may furnish grounds for suspicion of violation. Both the federal and state laws contain specific reference to drug addicts and it is only in exceptional cases, such as those of aged and infirm persons, that a practitioner is justified in furnishing an addict with the means of obtaining a supply of drugs.

Marijuana

It should be noted that the Harrison Narcotic Act does not regulate the production, manufacture, sale or use of marijuana. Instead, this is made the subject of separate federal regulatory legislation which is in terms almost identical with that on narcotics. A physician desiring to administer, dispense, prescribe or give away marijuana must, in order to comply with the federal act, first be registered for such purpose separately from his narcotics registration and must keep records similar to but independent of those showing disposition made of narcotics. The Wisconsin act includes cannabis, of which marijuana is a variety, in the definition of narcotic drugs, thereby making the act uniformly applicable to coca leaves, opium and marijuana.

Penalties

Violation of the statutes relating to narcotics or marijuana is made a crime, and the severe penalties imposed reflect a public policy which demands that the use of these drugs be limited to legitimate medicinal purposes. For violation of the federal narcotic act the statute provides penalties varying from a fine up to $2,000 and imprisonment up to five years, or both, to a fine up to $10,000 and imprisonment up to twenty years, or both, and for the imposition of more than one fine, or imprisonment, or both, for a given violation. The state penalties are not so heavy, being limited on the first offense to a maximum fine of $200, or a maximum jail sentence of three months, or both, and for any subsequent offense to a fine of $100 to $1,000, or imprisonment in the state prison up to five years, or both. The state statutes also provide that there shall be no prosecution under the state narcotic law where a person has been acquitted or convicted under the federal law for the same act or omission.

The penalty for violation of the federal marijuana law is a fine of $2,000 or imprisonment, up to five years, or both, and for violation of the general marijuana provisions of the state law, the same penalties as those set out above for violation of the narcotics provisions.

Important Federal Requirements and Date Lines

1. A physician desirous of using narcotics or marijuana in the course of his professional practice, who is registering for the first time, may do so at any time of the year. He should first request a narcotics application form from the office of the Collector of Internal Revenue, Federal Building, Milwaukee. This should be carefully filled out, witnessed or notarized, and returned to the collector, together with a special annual tax of $1.

2. Physicians who have registered before under the narcotics law will receive re-registration Form 678 from the collector of internal revenue in May of each year. This should be carefully prepared and returned along with the annual tax of $1 *on or before July 1 of each year.* A physician who does not receive a re-registration form on or before July 1 is under duty to request one from the collector.

3. There must accompany the registration application and annual tax a sworn inventory on Form 713 showing narcotic drugs on hand in the physician's office. This, like the re-registration and tax, must be filed on or before July 1 of each year.

4. A physician may *not* order narcotics on his own prescription blank, but must use the official duplicate order book prescribed by the collector of internal revenue, which may be purchased from the collector's office, Federal Building, Milwaukee, for 10¢. The order book may be requested on Form 679.

5. Unless a physician has registered, paid his tax, and filed an inventory, on or before July 1 of each year, it is a violation of law for him to administer, dispense, prescribe, give away or transport nar-

cotics or marijuana until he has first complied with the law in all above respects. In the case of narcotics it is a violation of law for the physician even to be in possession of such drugs under these circumstances.

6. Fines are imposed on a physician who either negligently or wilfully fails to keep or display in a prominent place in his office the stamps denoting payment of the special annual tax on the use of narcotics or marijuana for professional purposes.

7. A physician who maintains two or more offices in different locations must register each office separately and pay the special annual tax of $1 for each.

8. The physician should report stolen narcotics at once to the narcotics agent, Federal Building, at either Milwaukee or Madison.

9. The following should be reported promptly to the Collector of Internal Revenue, Federal Building, Milwaukee:

(a) Removal of office. This is merely a matter of re-registration and does not require a new permit or payment of an additional tax.

(b) Discontinuance. A registered physician desirous of discontinuing either his practice or the administration, prescription or dispensing of narcotics or marijuana should notify the collector of his intention not later than June 30, the close of the tax year. He will receive special instructions as to disposing of his stock, etc.

(c) Death. Notice of the death of a registered physician should be given the collector of internal revenue by his family, administrator or executor. The collector will forward instructions as to the disposition to be made of narcotics or marijuana on hand.

10. The physician should remember that if he desires to use marijuana in the course of his professional practice he must register, pay a tax and furnish an inventory on marijuana independently of those same requirements for narcotics, the latter being restricted by statutory definition to opium or coca leaves, or any compound or derivative thereof.

11. No registration is required under the Wisconsin act by physicians desirous of making professional use of coca leaves, opium or cannabis.

The Harrison Narcotic Act and the Practitioner*

By H. J. ANSLINGER

United States Commissioner of Narcotics, Washington, D. C.

THE drugs which come within the purview of Harrison Narcotic Act are opium and coca leaves, and any compound, manufacture, salt, derivative, or preparation thereof. A practitioner lawfully entitled to distribute, dispense, give away, or administer any of these drugs to patients upon whom he, in the course of his professional practice, is in attendance, may register under the act with the collector of internal revenue of his district, and pay an occupational tax of $1 per annum. It will be seen that a practitioner who is not qualified under the laws of a state or territory to distribute, dispense, give away or administer narcotic drugs, is not eligible for registration under the Harrison Narcotic Act. In the case of a medical practitioner, this means, generally speaking, that he must have a valid and unrevoked license, issued by the appropriate authority of his particular jurisdiction, to practice medicine.

Having duly registered and having paid the occupational tax, the practitioner is assigned a registry number, and receives a special tax stamp which must be kept posted conspicuously on the premises "where the business is operated," i.e., in the practitioner's office. In order to obtain a supply of taxable narcotic drugs or preparations for dispensing to patients in the course of medical treatment, the practitioner must now apply to the collector of internal revenue for a book of official order forms, the book containing ten originals and ten duplicate copies of the order form. The collector will furnish upon request a copy of the blank form upon which a book of order forms may be ordered and a remittance of 10 cents must accompany the application when forwarded to the collector, to cover the purchase price of the book of order forms. Before issuing the order forms the collector will cause to be shown thereon in a legible and permanent manner the name, address, registry number, and class number of the practitioner to whom they are supplied as well as the date of issuance and the collector's signature or his name and the initials of the issuing employee.

To Purchase Narcotics

Order forms are issued in duplicate and shall be executed in duplicate. They are arranged to permit the execution of the original and duplicate simultaneously by the insertion of a carbon sheet. An order for taxable narcotic drugs is prepared by the practitioner upon an original and duplicate order form, the original being signed by the practitioner and forwarded to a person, firm, or corporation qualified to sell taxable narcotics, such as a registered manufacturer or wholesale dealer. The duplicate copy of the form must be preserved by the practitioner for a period of two years and kept available for inspection by any federal or state officer authorized to make such inspection. I wish to emphasize at this point that the proper method of obtaining taxable narcotic drugs or preparations by a prac-

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titioner, for general use in his practice, is by the use of an official order form. It has been found that some physicians issue a so-called prescription for narcotics such as hypodermic tablets of morphine, marking the order "For office use." A retail druggist who fills such an order violates the law and besides incurring criminal liability, incurs civil liability to an occupational tax in a higher class than that of retail dealer, as well as a civil penalty.

The ordinary source of supply for the practitioner who wishes to obtain taxable narcotics for general use in his practice, is (1) a person, firm, or corporation registered under the Harrison Act as a manufacturer in Class 1 or (2) a person, firm, or corporation registered under said act as a wholesale dealer in Class 2. The average druggist who is registered as a retail dealer in Class 3 is qualified to fill lawfully issued prescriptions for narcotics, but may not under his Class 3 registration sell narcotics to a physician pursuant to an order form, except, under certain conditions, aqueous and oleaginous narcotic solutions. A druggist qualified by registration as a retail dealer may supply registered practitioners on order forms, in quantities not exceeding one ounce at any one time, with aqueous or oleaginous narcotic solutions, in which the narcotic content does not exceed a greater proportion than 20 per cent of the complete solution, to be used in legitimate office practice. A druggist qualified only by registration as a retail dealer may not supply a practitioner, pursuant to an order form, with a quantity of any other taxable narcotic drug such, for instance, as a tube of hypodermic tablets.

Some retail druggists, in order to accommodate members of the medical profession, register under the Harrison Act in Class 2 as a wholesale dealer in addition to their registry in Class 3 as a retail dealer. A retail druggist who has duly registered and paid the occupational tax as a wholesale dealer may, of course, supply a registered practitioner, pursuant to the latter's order form, with tax-stamped narcotic drugs such as a tube of hypodermic tablets, for use in professional practice.

Dispensing Narcotics

A practitioner, in the bona fide medical treatment of a patient, may dispense or administer narcotic drugs directly to the patient or he may issue to the patient a prescription for narcotics which prescription is filled by the retail druggist. The method of prescribing narcotics for patients is perhaps more general.

As to the formal requirements, a prescription for narcotic drugs must be dated as of and signed on the date when issued and must bear the full name and address of the patient and the name, address, and registry number of the practitioner. The prescription should be written with ink or indelible pencil or typewritten and must bear the signature of the practitioner. No government form of prescription is issued, the practitioner being permitted to use his own form, but the duty of properly executing the prescription rests upon the practitioner.

The refilling of a prescription for taxable narcotic drugs is prohibited. As a general rule, the partial filling of narcotic prescriptions is not permissible. If, however, a dealer is unable to supply the full quantity called for in a prescription and an emergency exists, he may supply a portion of the drug called for by the prescription, provided he makes a suitable notation on the face of the prescription of the quantity furnished and the reason for not supplying the full quantity on the back of the prescription, and advises the issuing practitioner thereof. No further quantity shall be supplied except upon a new prescription.

The furnishing of narcotics pursuant to telephone advice of practitioners is prohibited, whether prescriptions covering such orders are subsequently received or not, except that in an emergency a druggist may deliver narcotics through his employee or responsible agent pursuant to a telephone order, provided the employee or agent is supplied with a properly prepared prescription before delivery is made, which prescription shall be turned over to the druggist and filed by him as required by law.

A prescription, in order to be effective in legalizing the possession of unstamped narcotic drugs and eliminating the necessity for use of order forms, must be issued for legitimate medical purposes. The responsibility for the proper prescribing and dispensing of narcotic drugs is upon the practitioner, but a corresponding liability rests with the druggist who fills the prescription. An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of the act; and the person filling such an order, as well as the person issuing it, may be charged with violation of the law. In the case of narcotics dispensed by the practitioner directly to the patient, the same standard applies, i.e., that the drugs shall be dispensed only in the course of professional practice.

Addicts

It is obviously impossible to lay down any general rule as to what is meant by the "course of professional practice" when applied to all of the infirmities to which flesh is heir. However, in a case which involved the prescribing of narcotic drugs to addicts, the Circuit Court of Appeals for the Sixth Circuit propounded to the United States Supreme Court the following question:

If a practicing and registered physician issues an order for morphine to an habitual user thereof, the order not being issued by him in the course of professional treatment in the attempted cure of the habit, but being issued for the purpose of providing

the user with morphine sufficient to keep him comfortable by maintaining his customary use, is such order a physician's prescription under exception (b) of section 2 (of the Harrison Narcotic Law)?

The United States Supreme Court held that

To call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required. That question should be answered in the negative.

Webb and Goldbaum v. United States (1919) 249 U. S. 96.

The Supreme Court emphasized this rule in a later case involving the prescribing of narcotics by a practitioner for an addict, by holding, in part, as follows:

Manifestly the phrases "to a patient" and "in the course of his professional practice only" are intended to confine the immunity of a registered physician, in dispensing the narcotic drugs mentioned in the Act, strictly within the appropriate bounds of a physician's professional practice, and not to extend it to include a sale to a dealer or a distribution intended to cater to the appetite or satisfy the craving of one addicted to the use of the drug. A "prescription" issued for either of the later purposes protects neither the physician who issues it nor the dealer who knowingly accepts and fills it.

Jin Fuey Moy v. United States (1920) 254 U. S. 189.

It may be stated that the Supreme Court has laid down the general rule that the prescribing or dispensing of narcotic drugs to addicts merely for the purpose of gratification of drug addiction cannot be considered as prescribing or dispensing narcotic drugs in the course of professional practice only. Practitioners who so dispense or prescribe narcotics are therefore liable to prosecution under the law. A sale of narcotic drugs made for the purpose only of catering to drug addiction is not a sale made in good faith and in the course of professional practice. A. W. Boyd v. United States (1926) 271 U. S. 104.

Upon trial of a practitioner upon charges of illegal dispensing of narcotics it has been held that, the issue being whether the drug was dispensed in the legitimate course of defendant's practice as a physician, evidence of experts as to the proper method recognized by the medical profession for the treatment of narcotic addicts is admissible on that issue. Reeves v. United States (C.C.A. 5th) 263 Fed. 690; see also Melanson v. United States (C.C.A. 5th) 256 Fed. 783; Sevensma v. United States (C.C.A. 6th) 278 Fed. 401; Strader v. United States (C.C.A. 10th) 72 F. (2d) 589; Hawkins v. United States (C.C.A. 5th) 90 F. (2d) 551.

Those practitioners, fortunately comparatively few in number, who have commercialized their profession by catering to drug addicts in complete disregard of the tenets of professional practice, and who find themselves on trial charged with offenses against the narcotic laws, nearly always resort to a claim of entrapment as a defense. A representation is made on behalf of the defendant physician, and it is sought to be substantiated, that he had no intention of transgressing the law, but that he was enticed into selling or prescribing the drug for improper purposes by the investigating officer or by someone associated with that officer. It should be stated at this point that an investigating officer is not authorized to commence an active investigation of the alleged narcotic irregularities on the part of a practitioner without first securing express authority to do so from his district supervisor, and that authority is not granted unless the investigation is based on well-founded suspicion, strong circumstances or trustworthy and reliable information that such violation is being committed. The rule which the Federal courts apply in this regard may be found most completely stated in a charge to the jury which was quoted with approval by the United States Circuit Court of Appeals for the Eighth Circuit in W. V. Smith et al v. United States (1922) 284 Fed. 673. A pertinent excerpt from this approved charge to the jury follows:

It is no enticement to ask a physician to write an illegal prescription, if you suspect that he might do it, and you want to find out if he does it, nor to ask a druggist to sell narcotics illicitly, because both of them know better, and if they are going to obey the law, why they won't do that in response to any form of petition or inducement, and it is perfectly within the rights of investigating officers to determine, by means that have been here disclosed, whether a party, or parties, are engaged in violation of the law, and if they are, to take steps accordingly, so that I wish to disabuse your minds of all this confusion that this, in itself, was such an unwarrantable offense on the part of the Federal officers that it relieves this offense charged, if you find any offense was committed, of its character as such offense.

See also Neuman v. United States (C.C.A. 4th) 299 Fed. 128; Hodge v. United States (C.C.A. 6th) 13 F. (2d) 596; Swallum v. United States (C.C.A. 8th) 39 F. (2d) 390; Ratigan v. United States (C.C.A. 9th) 88 F. (2d) 919. It will be seen that the Bureau rule of enforcement practice to avoid illegal entrapment is well within the limits of the rule established by the courts.

The Narcotic Bureau has never sanctioned or approved the so-called reductive or ambulatory treatment of addiction for the reason that where the addict controls the dosage he will not be benefited or cured. Medical authorities agree that the treatment of addiction, with a view to effecting a cure, which makes no provision for confinement while the drug is being withdrawn, is a failure, except in a relatively small number of cases where the addict is possessed of a much greater degree of will power than that of the ordinary addict. The following report of a special committee of physicians, which is understood to have been adopted by the American Medical Association, is quoted from the *Journal of the American Medical Association*, issue of June 14, 1924:

Your committee desires to place on record its firm conviction that any method of treatment for narcotic drug addiction, whether private, institutional, official or governmental, which permits the

addicted person to dose himself with the habit-forming narcotic drugs placed in his hands for self-administration, is an unsatisfactory treatment of addiction, begets deception, extends the abuse of habit-forming narcotic drugs, and causes an increase in crime. Therefore, your committee recommends that the American Medical Association urge both federal and state governments to exert their full powers and authority to put an end to all manner of such so-called ambulatory methods of treatment of narcotic drug addiction, whether practiced by the private physician or by the so-called "narcotic clinic" or dispensary.

In the opinion of your committee, the only proper and scientific method of treating narcotic drug addiction is under such conditions of control of both the addict and the drug, that any administration of a habit-forming narcotic drug must be by, or under the direct personal authority of the physician, with no chance of any distribution of the drug of addiction to others, or opportunity for the same person to procure any of the drug from any source other than from the physician directly responsible for the addict's treatment.

The following statement is quoted as an excerpt from an "Introduction," by Dr. Morris Fishbein, to a series of articles by various authors on "Indispensable Uses of Narcotics," published in the *Journal of the American Medical Association*, March 14 to June 6, inclusive, 1931:

Physicians may, by the exercise of more thought in practicing, do much to avoid censure in relation to narcotic addiction. They may substitute, whenever possible, non-habit-forming drugs in the place of morphine or other opium alkaloids. When narcotics are indispensable, however, as shown in this series of articles, no more should be administered than is necessary to achieve the desired end. Patients requiring daily administration should be seen often by the doctor and the amount of drugs ordered or supplied should not exceed that required by the patient until seen again. Independence of administration on the part of nurses should be strictly limited to prescription and any change in treatment should be in writing.

For these views in disapproval of the so-called ambulatory treatment for drug addiction, we can find some support, at least by strong implication, in the language of a decision of the United States Supreme Court in the case of United States v. Morris Behrman (1922) 258 U. S. 280. To quote, in part, from this decision:

Undoubtedly doses may be varied to suit different cases, as determined by the judgment of a physician. But the quantities named in the indictment are charged to have been entrusted to a person known by the physician to be an addict, without restraint upon him in its administration or disposition by anything more than his own weakened and perverted will. Such so-called prescriptions could only result in the gratification of a diseased appetite for these pernicious drugs, or result in an unlawful parting with them to others, in violation of the act as heretofore interpreted in this court, within the principles laid down in the Webb and Jin Fuey Moy cases.

Federal Bureau Policy

The Bureau of Narcotics, in carrying out its duty to enforce the Federal narcotic laws, endeavors to avoid any action that might possibly harass or even inconvenience the conscientious law-abiding practitioner. It attempts to inform the profession relative to the technical requirements of the law and the regulations in order to forestall irregularities that might otherwise be committed, unintentionally by the ethical practitioner, through lack of such information. It must and does attempt to bring to the bar of justice those comparatively few practitioners who disregard the law, and the ethics and high ideals of their profession by converting their offices into depots for the illicit distribution of narcotic drugs. That the physician in the last-mentioned class represents an important factor in the diversion of narcotic drugs will be appreciated from the fact that, in a few recent cases in which the offending physicians were convicted, the tabulation of prescriptions disclosed that one group of four physicians had, within a period of twenty-three months, written over 19,000 prescriptions for numerous drug addicts, calling for a total of 66 pounds of morphine.

SYMPOSIUM ON INDUSTRIAL PUBLIC HEALTH NURSING SERVICES

A symposium on industrial public health nursing services, sponsored by the State Board of Health and the industrial nurses of Wisconsin, will be held February 20, 21 and 22 in the Hotel Wisconsin, Milwaukee. Agencies cooperating in the symposium include:

Wisconsin State Nurses Association
State Medical Society of Wisconsin
University of Wisconsin
Wisconsin Industrial Commission
Wisconsin Association of Manufacturers
Marquette University
Wisconsin Anti-Tuberculosis Association
Milwaukee City Health Department
Milwaukee Association of Commerce
Industrial Relations Association
Employers Mutuals Liability Insurance Company of Wausau

Dr. Paul A. Brehm, supervisor of the industrial hygiene unit, State Board of Health, Madison, as general chairman of the symposium, has arranged the three-day program which will feature addresses by: Mayor Carl F. Zeidler, Milwaukee; Drs. Stanley J. Seeger (chairman, Industrial Health Council, A. M. A.), E. Miller, E. R. Krumbiegel, Norbert Enzer, M. J. Reuter, M. Fernan–Nunez, and J. A. Carswell,—all of the Milwaukee; Dr. Merritt Jones, and Mr. B. E. Kuechle (vice-president, Employers Mutuals Insurance Co.), Wausau; Dr. W. S. Middleton, dean of the University of Wisconsin Medical School, Madison; Dr. Copeland Smith of the National Association of Manufacturers, New York City; Dr. R. D. Mudd, Saginaw, Mich.; and several representatives of federal and state industrial health services and of industrial nursing groups.

No registration fee will be charged. **Watch for a complete program of the symposium in the January issue of The Journal.**

Tax and Permit Provisions of State Liquor Laws

UNDER the laws of Wisconsin, "intoxicating liquors" are defined as: ". . . all ardent, spirituous, distilled, or vinous liquors, liquids, or compounds, whether medicated, proprietary, patented, or not, and by whatever name called, containing one-half of one per cent or more of alcohol by volume, which are fit for use for beverage purposes . . ." Sec. 176.01.

Section 139.26 imposes a tax on intoxicating liquors but exempts those used by hospitals for medicinal or hospital purposes. Sec. 139.26 (1) and (1a). Section 176.401, Wisconsin Statutes, provides tax exemption for alcohol "intended for use and used in the manufacture and sale" of medicinal, pharmaceutical and antiseptic preparations when unfit for beverage purposes. There is no tax exemption for intoxicating liquors prescribed for medicinal purposes by a physician other than as those may be purely medicinal and not fit for beverage purposes. A substantial penalty is provided if patented, proprietary, medicinal, pharmaceutical, antiseptic, or toilet preparations are sold for intoxicating beverage purposes. Sec. 176.401 (2).

Those who deal in intoxicating liquors are generally required to secure a state license, but the physician (and hospital) is exempt from this requirement where his use thereof is "in the bona fide treatment of the sick or in using or prescribing such alcohol for such bona fide treatment." However, the physician must secure from the state treasurer a permit to receive shipments of alcohol for medicinal purposes. This permit will be issued without charge to any person who proves to the state treasurer that he uses such alcohol for medicinal purposes. Sec. 176.04 (3), also 176.404 (1), Wisconsin Statutes.

Because of the importance of the provisions in the laws relative to physicians and surgeons prescribing liquor in unnecessary amounts or under unnecessary circumstances the following provisions contained in Section 176.19 are printed here in full:

(1) It shall be unlawful for any physician or surgeon to prescribe intoxicating liquors for any person when unnecessary for the health of such person, or to prescribe a greater quantity of such liquor than proper for the ailment or disease of such person, with intent to evade or assist in evading any of the provisions of this chapter. Nothing in this chapter shall be construed as prohibiting any hospital or one licensed to practice medicine or surgery from having and using alcohol, in any form, in the bona fide treatment of the sick, nor as requiring either to have a permit or license to have, use, or prescribe the same for such bona fide treatment.

(2) Any physician or surgeon violating any of the provisions of this section shall be punished by a fine of not less than two hundred and fifty dollars nor more than one thousand dollars or by imprisonment in the county jail or house of correction not more than six months; and conviction for a second offense within any one year shall be ground for revocation of such defendant's license to practice medicine and surgery in this state.

Medical Aspects of Marriage Laws

THE Wisconsin statutes impose a number of conditions which must be fulfilled before a marriage can be recognized as valid in this state. Some of these are quite unrelated to medicine, but others have medical aspects. Only those which are peculiarly within the province of the practicing physician will be indicated below.

Premarital Examinations

1. *Freedom of male from venereal disease.*—The law requires all male applicants for a license to marry to obtain and file with the county clerk a certificate to the effect that the physician has thoroughly examined him and believes him to be free from any venereal disease, the examination to have been made within fifteen days of the marriage application.

The certificate provided by statute is in the following form:

I, _____ (name of physician), being a physician, legally licensed to practice in the state of _____, my credentials being filed in the office of _____ in the city of _____county of_____ State of _____, do certify that I have this _____day of _____19____ made a thorough examination of _____ (name of person), and believe him to be free from all venereal diseases.

_____(Signature of physician)

The physician must be one duly licensed to practice in Wisconsin or in the state where the male applicant resides. The fee for such examination and certificate, by statute, shall not exceed $2; the examination is made without charge, on request, by the county or asylum physician of any county where the applicant is an indigent. If, in the opinion of the examining physician, a microscopic examination for gonococci is required, it shall be made by the State Laboratory of Hygiene free of charge at the request of the examining physician.

2. *Negative Wassermann tests for both applicants.*—*Both* parties to a proposed marriage shall, within fifteen days of their application, be given a Wassermann or other standard blood test for syphilis. The test must be performed in a laboratory approved by the State Board of Health as competent to make such examination, or at the Wisconsin Psychiatric Institute free of charge, and if the results are negative a certificate in the following form is given the applicant:

I, _____(name of physician), being a physician, legally licensed to practice medi-

cine and surgery in the state of _____ my credentials being filed in the office of _____ in the city of _____county of _____ state of _____ do certify that_____ (name of person) was given the Wassermann or other standard blood test for syphilis at _____ _____(name of laboratory) from blood taken by _____ on the _____ day of _____ 19____ and that the result of such test was negative.

_____
(Signature of physician making laboratory test)

Note: There is provision for non-residents securing their blood tests in their own state requiring the submission of the original certificate from the laboratory together with a statement from the State Health Officer of the state (or his representative) to the effect that he believes the laboratory competent to make the test.

3. *Physician penalties.*—The statutes provide that any physician who knowingly and wilfully makes any false statement in either of the certificates set out above, shall be punished by a fine up to $100 or by imprisonment up to six months.

4. *"Wassermann-fast" cases.*—Section 245.11(4) provides:

In the case of an individual whose laboratory test for syphilis results in a positive finding, when in the opinion of his attending physician the individual no longer has syphilis in an infective or communicable stage, the state board of health may review the findings and clinical evidence through a deputy state health officer and thereafter the state health officer is empowered to grant a certificate to the county clerk that the individual is not in the infective or communicable stage of syphilis if such be his best judgment.

The effect of the above subsection is to make it possible for a syphilitic applicant to marry so long as his disease is not in an infective stage. Under a rule of the State Board of Health, made in September, 1939, a case of syphilis is ordinarily not considered "Wassermann-fast," or noncommunicable, until there have been at least twenty arsenical treatments and a similar number of treatments with heavy metals, all at proper intervals.

To avoid unnecessary correspondence, and in order to enable the examining physician to supply lacking information, forms have been prepared and are available from the offices of the State Board of Health on which physicians requesting special consideration of noncommunicable cases may make application to the state health officer. In accordance with provisions of the above section when this form is submitted by the physician, including his statement that in his opinion the individual no longer has syphilis in an infective or communicable stage, and if, after review of the files and clinical evidence by a deputy state health officer, it is the best judgment of the state health officer that the individual is not in an infective or communicable stage, he issues the required certificate which is sent directly to the county clerk.

The Attorney General of Wisconsin has recently ruled that only applicants who have submitted to a blood test for syphilis within fifteen days of applying for a marriage license, which test resulted positively, may avail themselves of the special procedure above provided. See XXIX Atty. Gen. 354 (adv. sheets).

Marriage Laws

While the physician is not professionally concerned with the marriage laws of the state except insofar as he may be directed or authorized to make antenuptial physical examinations, nevertheless he is not infrequently asked for general advice in his position as family counselor. In Wisconsin, civil, not ecclesiastical, law governs the marriage contract. It is nevertheless complicated and to a considerable extent an unadjudicated field of contract law.

Under the Wisconsin law every male person who shall have attained the full age of 18 years and every female who shall have attained the age of 15 years is capable of contracting marriage if otherwise competent. Between the ages of 18–21 years as to the male and 15–18 years as to the female, consent of the parents or guardian, or an order of the county court of the county in which the marriage license application is pending, is necessary.

An attempted marriage on the part of one who is insane, imbecilic, feeble-minded, epileptic or idiotic is absolutely null and void in this state, cannot be ratified, and may be challenged by a party to the marriage or by one validly interested therein and either during or after the lives of either or both parties to the marriage. These are apparently the only marriages which are absolutely null and void from the beginning.

Where parties under age have failed to secure the consent of the parents, but have been married in good faith, their marriage is not void but merely voidable upon positive action by one of the parties or his guardian. Where the parties marry while under the lawful ages above set out, the marriage may be annulled unless the parties affirm the contract after reaching 15 years if it was the female who was not of proper age, or 18 years in the case of the male.

If a resident, who is disabled or prohibited by Wisconsin laws from marrying here, does so, such marriage is null and void for all purposes in this state. This has reference only to attempted marriage by the insane, imbecilic, feeble-minded, epileptic or idiotic. Other marriages, even though contracted in another state in order to avoid Wisconsin regulatory laws such as those relating to antenuptial physical examinations, are not invalid in Wisconsin. Where the ceremony is performed outside of Wisconsin and the parties return to it to reside, they are required under the provisions of section 69.48, Wis. Stats., to fill out and file a blank marriage certificate with the local registrar of vital statistics within ten days after their return.

As previously indicated, the marriage laws of this state are complicated and cannot be applied by general rule to any given situation. The physician should have a general awareness of them in the sense that all matters concerning the public welfare and particularly the field of public health come within his professional concern.

Malpractice and Malpractice Suits

THE Wisconsin statutes provide that complainants in personal injury actions must give notice of their claim within two years after the "happening of the event" causing the damage claimed, unless they have begun action by service of summons and complaint within the same period. Section 330.19 (5). The Wisconsin Supreme Court has held that no matter whether a cause of action based upon malpractice is predicated upon a tort (wrongful act) or contract (breach of agreement) liability, the action is essentially one for personal injury and falls within this particular statute. See Frechette v. Ravn, 145 Wis. 589; Klingbeil v. Saucerman, 165 Wis. 60. This is likewise true although the action may be one for loss of services, nursing and medical expense. See: Shovers v. Hahn, 178 Wis. 615. Our Supreme Court has also held that an infant is not excused from complying with this statute. Hoffmann v. Milwaukee Electric, 127 Wis. 76. Thus it follows that the provisions of the statute are applicable to individuals incapacitated by reason of insanity or a similar cause.

But if the statutory notice is given by those incapacitated by reason of infancy or insanity, the ordinary statute of limitations is extended. In the case of infants, the statute is extended until they reach the age of twenty-one years. If the individual is insane, the statutory period of limitations will be extended five years, unless he recovers within the six-year period. If he recovers after the ordinary period of limitations has expired but before the eleven-year period has expired, he must bring his action within one year after the disability ceases.

In order to protect himself properly in event of a malpractice claim, certain routines should be followed by every physician. (In this connection see also p. 1076 of this Journal.) These routines may avoid unmerited claims arising through misunderstanding or precipitated by some thoughtless remark. In the WISCONSIN MEDICAL JOURNAL 27:573–575 (Dec.) 1928, certain precautions were suggested, and their substance is restated and somewhat augmented here, to help in avoiding malpractice actions:

Causes For Misunderstanding

1. Medicine is a science but its proper application is largely an art. It is unwise to make unnecessary positive statements, particularly in early diagnosis or treatment in the broad field of human ills. When you say, "It is nothing but a cold; take these, go back to work and forget it," and subsequently it is found that the patient had incipient tuberculosis at the time he saw you, he is sure at least to resent your too-positive attitude if nothing more.

2. Few of the laity understand that an exact anatomical alignment in a fracture is not usual or necessary; that you are trying to attain it but that you are primarily interested in the functional result. When this is not explained and the patient subsequently sees an x-ray film showing only a fair anatomical result, who is to blame him if he fears he has had poor treatment? Frankness in explaining at least something of this to "fracture patients" is urged; then they will at least appreciate the difficulties that beset the paths of the best of men and will be thoroughly satisfied to find a good functional use restored.

3. The physician who promises quick results and fails to attain them frequently finds his patient seeking another physician.

4. Attorneys frequently say that street corner advice is worth just what one pays for it, yet it occurs with a fair degree of frequency that an attorney will ask a physician for street corner advice on a supposed course of treatment. Be careful what you say for he may be trying to arrive at conclusions whether a client has a real malpractice case. What he tells you will likely be but one side of the case and when all is known to you, your first opinion may be reversed.

5. In these days of compensation insurance a new cause for misunderstandings between physicians exists. It is an everyday occurrence for insurance carriers to demand that "their physician" see the insured. Reports are occasionally written by such physicians scoring the acts of the family physician. The insurance company may show this report to the claimant to show how his period of recovery was prolonged by faults of the family physician explaining that the company could hardly be expected to pay for that period. Again it is suggested that the second physician be sure he is in possession of all the facts before he scores the family physician. If he did his work carefully and exercised the same degree of skill as other practitioners in the community he will not be found guilty of malpractice even though a better treatment might have been had in a distant, large hospital with more adequate facilities.

6. When a patient does not pay his bill and the ability to pay appears to exist many physicians turn the bill over to a collection agency which may start suit in a physician's name. The man who does not pay his just debts within a reasonable period of time when ability to pay exists, is frequently not a man of honor or character. Such a man may bring a counterclaim alleging malpractice as a means of blackmailing the physician into dropping the original action for collection of fees. Indeed, records show a fairly large percentage of malpractice suits are begun as counterclaims rather than as original actions. The understanding physician, appreciating the danger in counterclaims on the part of the unscrupulous, will watch carefully that bills of such persons are not pressed unduly until after two years have passed following the last treatment. This generally means an added delay of but a few months and is a wise precaution when dealing with the type of

people mentioned. After two years malpractice is outlawed but the statute of limitations still allows four years more in which to collect the debt.

7. No physician should pass over a case of definitely suspected fracture, dislocation or foreign body without advising x-ray pictures to make certain the diagnosis, if it is impossible by the unaided senses to exclude these conditions. Failure to give such advice may lead to a malpractice suit.

8. The law does not require you to respond to a call by anyone who applies. But after you have once accepted employment, you assume responsibilities with respect to attendance that continue throughout employment. If you yourself desire to terminate those responsibilities, you may,—provided you give reasonable notice, in view of the condition of the patient. as will permit the patient to employ another attendant. This is a general rule of law; its applicability will vary as to each case.

Routine to Be Followed

Certain precautions should be followed as a routine if a physician desires to take every precaution to avoid malpractice actions.

1. Every x-ray plate should show the patient's number, the date, and at least the initials of the operator. The patient's record should show clearly the number of x-ray exposures.

2. In the case of fluoroscopic examinations the examiner should by all means note on the patient's record at the time the length in time of examination under the rays and the setting of the machine.

3. Do not put your faith in "fool-proof" apparatus. Have your equipment, such as your x-ray and fluoroscopic machines inspected regularly, for the assurance of the maker is no protection to you if something goes wrong.

4. Take no x-ray pictures; do no fluoroscopic examinations without noting on the record the patient's statement as to when he was last exposed. If the patient is a "traveler" he may be burned through multiple exposures.

5. In fracture cases take an x-ray picture routinely on the day the patient is released. Besides providing you with the opportunity to explain functional versus anatomical results, you have evidence to prove the condition of the patient when released. Then if the patient has a subsequent accident he cannot substantiate a claim of non-union when released.

6. If your patient does not accede to x-ray examination you have advised, or desires to leave the hospital before you think it wise, protect yourself against what might happen by reducing your advice to writing and handing a copy to the patient in the presence of at least one and preferably two witnesses. A written statement, signed by the patient in the presence of witnesses, refusing permission for use of the x-ray by you, or further hospitalization, is preferable. Following such procedure is of immeasurable value in event of future litigation.

7. It seems hardly necessary to state that in full records lies your greatest protection. Such records, made at the time, are the best evidence in court of conditions you found and treatment you advised. If your patient is not following your advice, be sure to make note of that at the time.

8. The importance of obtaining consent in all procedures involving operations or autopsies must never be overlooked. Neither good faith, patient welfare, nor good medical practices will stand alone as a defense against failure to secure consent, except only in those cases where an emergency makes it impractical for a physician to confer with the patient, or his guardian. See: Throne v. Wandell, 176 Wis. 97.

Burden that of surgeon.—While it is probably routine in all well-regulated hospitals to secure a written consent from a patient about to undergo an operation, it must not be understood as any the less the surgeon's responsibility. And while oral consent is sufficient, difficulty of proof as to the fact that it was given condemns this procedure as insufficient protection.

Extent of consent.—A physician authorized to perform a specific operation acts at his peril in performing another or different one; nor, apparently, is he authorized to perform a more extensive and involved operation than that authorized. In all cases the consent should be sufficiently broad to include any procedures whether anticipated or not which may confront the surgeon at the time of operation. Consent must be obtained without fraud, and thus it is the safer policy to explain that sometimes unanticipated conditions or complications arise, so that, for the patient's welfare, the physician should be authorized to deal with them as they may arise.

Who may give consent.—Under ordinary conditions, and except in the emergency case as noted elsewhere, the person operated upon, if not a minor nor incompetent, may give his consent for any lawful operation. In the case of minors and incompetents, only those in the position of legal guardians are empowered to give such consent. The mere fact that a relative such as a brother endeavors to authorize an operation is insufficient, unless legal authority to do so exists.

Autopsy. Consent is of equal importance where an autopsy is to be performed, and if it is desired to remove organs or specimens, the consent should so provide. The Wisconsin Supreme Court, in the case of Koerber v. Patek, 123 Wis. 453, held that—

> We can imagine no clearer or dearer right in the gamut of civil liberty and security than to bury our dead in peace and unobstructed; none more sacred to the individual, nor more important of preservation and protection from the point of view of public welfare and decency; certainly none where the law need less hesitate to impose upon a wilful violator responsibility for the uttermost consequences of his act. We recognize, of course, that public welfare may and does require governmental control in many respects for protection of life and health of the people, and for discovery of crime connected with the death of a person, and to such interests the private right is subservient so far as necessary. Upon this ground rest cases of autopsies upon dead bodies under public authority, and to satisfy police regulations for ascertainment of cause of death.

Dr. W. C. Woodward, recently resigned director of the Bureau of Legal Medicine and Legislation of the American Medical Association, has pointed out that, subject to the legal rights of coroners, the right to control and custody of a dead body vests primarily in the surviving spouse, if there is any, and if not, in the next of kin in order of their consanguinity.

In the Koerber case, cited above, the Wisconsin Supreme Court also held that—

> In absence of any surviving spouse, situations become subject to such complications that it probably is not wise, if proper, to attempt to declare general rules beyond the case actually presented. Suffice it to say that the duty and right of the parent toward the body of a minor child dying a member of his household, or of the adult child toward a widowed parent, either a member of the child's family circle, or not a member of any other, seems to clear to warrant discussion.

And while Wisconsin has not yet stated any further rules, Dr. Woodward suggests that as a practical matter: "Generally it will be found that some one of a given group will be at the place of death and will assume charge of the body, and it is to such a one that application will generally be made for permission to perform an autopsy. Almost universally, such consent is recognized as valid by other members of the group; but even if it should not be the dissenting members would have difficulty in proving they had suffered damage by any supposed trespass on their rights."

However, it is only prudent to suggest that where there is doubt, great care should be exercised, and the advice of a local attorney sought. Even where the autopsy is performed at the request of a coroner the physician is protected only when the coroner properly has jurisdiction of the body. Generally speaking, that means in Wisconsin either that the coroner must have ordered an inquest—on his own motion or at the request of the district attorney because there is good reason to believe that murder or manslaughter has been committed—before asking the doctor to perform the autopsy, or that a cremation of the body is planned and in the coroner's judgment an autopsy is warranted. When the physician is in any doubt as to the coroner's authority to authorize an autopsy, he would do well to check first with the district attorney and then with his own attorney on the question of the coroner's proper jurisdiction.

Character of suit.—Physicians generally understand that under the Wisconsin law, if a malpractice suit is not begun within two years after the happening of the event upon which the cause of action arose, proper notice must be given. The Wisconsin court has held that this is true whether the action be one in behalf of a minor, and whether based on breach of contract or negligence. But it is not clear whether the same law applies in the case of autopsies without consent. An action involving an unauthorized autopsy may be predicated differently, and not come within the statutory contemplation of an action arising out of a personal injury.

Other examinations; treatments.—It must be pointed out that many statutes come into play in connection with specific matters of examination and treatment. With these the physician is generally well acquainted. For example, authorization for treatment may be secured from the employer in workmen's compensation cases, but this does not release the patient's right to control, even though at some possible cost to himself, the question whether he shall or shall not receive some particular treatment. Yet even this may not be the right of the patient with venereal disease. The law becomes more complex, not more simplified, with the extension of legislative programs affecting the public security and welfare; but in all this the physician must keep in mind the general rules that govern the patient's welfare and his personal relationship to him.

For a more detailed treatment of the problem of consent to autopsies see the article, "Duties of Coroner," in this issue.

9. If your operative reports are typed, read them carefully and sign your name in full. Do not just initial typed records. Never sign hospital operative records in blank to accommodate the hospital.

10. In the delegation of certain duties or functions to a technician, care should be exercised that such functions are those which may be called mechanical or ministerial and require the exercise of no judgment or discretion by the technician properly that of the physician.

The Case of Threat

Assuming that some day you are given summons in a suit, or a suit is threatened, these pointers may be helpful.

1. Report the suit or threat to your insurance company *at once.*

2. You may be invited to call on the patient's attorney to "avoid" a suit. Let your attorney do that for you.

3. Tell your own attorney all the facts even though some do not reflect credit on your judgment. He cannot help you if you "hold out" on him.

4. Do not be offended if a friend of yours is going to testify for the plaintiff. Better a friend who will give you a square deal than a quack whose testimony is purchasable.

5. Be careful of too-positive statements. Tell what you know in terms the jury can understand and admit that you do not know everything in medicine. When the plaintiff's attorney gets you to making one wholly positive statement after another he is soon apt to discredit your entire testimony by showing that authorities do not agree with some two or three statements and q. e. d.—you are "all wrong."

Every malpractice action undermines the confidence of the public in all physicians and it is said that a dozen new suits are commenced based upon the publicity of a new case. You are your brother's keeper in maintaining a justified public confidence. Let no improper act of yours lead to a betrayal of that trust.

Statutes Relating to Producing Miscarriage or Abortion; After-Treatment and Patient Records

WISCONSIN has two statutes dealing with the offense of causing an abortion or miscarriage. These statutes are printed here in full.

340.16 **Manslaughter, second degree.** Any person who shall administer to any woman pregnant with a child any medicine, drug or substance whatever, or shall use or employ any instrument or other means with intent thereby to destroy such child, unless the same shall have been necessary to preserve the life of such mother or shall have been advised by two physicians to be necessary for such purpose, shall, in case the death of such child or of such mother be thereby produced, be deemed guilty of manslaughter in the second degree.

351.22 **Producing miscarriage.** Any person who shall administer to any pregnant woman, or prescribe for such woman, or advise or procure any such woman to take any medicine, drug or substance or thing whatever, or shall use or employ any instrument or other means whatever, or advise or procure the same to be used, with intent thereby to procure the miscarriage of any such woman shall be punished by imprisonment in the county jail not more than one year nor less than six months or by fine not exceeding five hundred dollars nor less than two hundred and fifty dollars, or by both such fine and imprisonment in the discretion of the court.

Note that the section relating to miscarriages (a lesser offense) does not contain an express exception for the necessitous circumstances.

After-Treatment

The position of the physician called to treat a patient suffering from the results of an intended and incomplete abortion is a difficult one, and may be precarious as well. Not infrequently the abortionist merely starts the abortion, advising the woman to consult her own physician for all future care. If the woman dies, suspicion may well turn to those near at hand, and the innocent physician may find himself involved in unfortunate publicity as a result of his attendance on the patient at the time of death.

The most satisfactory course would involve the patient's complete disclosure of the facts to the proper authorities but this is often difficult, if not impossible, of accomplishment. The woman obviously wishes to conceal her condition and its cause, and not infrequently does so until death. While the physician may properly urge such disclosure, he is not himself burdened with that responsibility for he must be ever mindful of those principles which make the welfare of the patient his chief concern.

When a physician is confronted with this type of case, he can, and should, insist that at least one other physician be called in before treatment is given. Preferably, and for obvious reasons, the consulting physician should not be one associated with the attendant physician. Their joint testimony as to the woman's condition would almost invariably negative the charge that any operation performed in the course of treatment was itself an abortion.

In an emergency case, when no other physician is available, it is proper to insist upon the patient signing a written statement, in the presence of witnesses, if possible, reciting the facts with reference to the performance of the abortion, including the name of the abortionist—such statement to be made with the understanding that the physician may use it in event of his needing it for his protection.

In State v. Law, 150 Wis. 313, a physician called to treat a woman after an abortion refused to take charge of her unless she made a full statement concerning the abortion, which he insisted upon for his own protection and to enable him to institute proper treatment. The Supreme Court of Wisconsin said: "It was a very proper request for him to make under the circumstances." Thus there is judicial recognition, by the highest court in Wisconsin, that it is proper for a physician to take precautionary steps to protect himself in such a situation.

Third Annual Congress on Industrial Health

Industrial Health is of exceptional interest at this time when national preparedness depends so greatly on industrial production. The attention of physicians is called to the program of the Annual Congress on Industrial Health published on pp. 1117–1118 of this issue. This will be the third of these meetings sponsored by the Council on Industrial Health of the American Medical Association. They are designed to acquaint the physician and others with the rapidly expanding importance of preventive medicine and surgery applied to industrial organization.

Since every man hour of production is vital at this time, the program of the congress is intended to be as helpful as possible to physicians called on to control those factors which in the past have contributed greatly to the incidence and costs of industrial absenteeism. In the field of trauma the hand and the eye have proved to be particularly vulnerable. Symposiums have therefore been developed to present the best current opinion on the management of these costly forms of industrial disability. Of the occupational diseases, dermatitis has long been recognized as the most troublesome. A series of demonstrations has been planned to include discussion of the criteria for diagnosis of industrial cutaneous disorders as well as accepted methods for the treatment and placement of susceptible employes. Among non-occupational diseases the common cold and influenza annually exact an enormous toll through loss of earning capacity and disruption of production schedules.

Outline of Laws Governing Collection of Accounts

THIS article is designed as an outline of some of the more important every-day aspects of collection law, and to suggest certain practical devices of aid in the collection of accounts of special interest to the physician. Blank promissory notes, judgment notes, and chattel mortgages may be obtained from various stationer's supply houses. Their use may facilitate, but will be no guaranty, of payment. In the final analysis, a sympathetic understanding of a debtor's position and a willingness to cooperate with him are surer means, as a general rule, of ultimate collection than resort to legal action. In involved matters, in the actual trial of cases in Justice Court, or where large sums are involved, services of a local attorney should be secured.

Liability For Services Rendered

Generally, the person who contracts for the services is responsible for payment thereof, but in certain cases there are qualifications of that rule.

Husband-wife.—A husband is liable for the reasonable value of *necessities* furnished his wife and minor children. Essential medical services are necessities. However, he is not liable for bills which his wife incurred before their marriage, or after they are divorced. A married woman living with her husband is not liable for medical services out of her separate estate, unless she *expressly* contracted for them upon her own credit, or unless she guaranteed payment (in writing) by her husband.

Guardian-ward.—Guardians are empowered by statute to apply the personal property and the income from the property "as far as may be necessary for the suitable education, maintenance, and support of the ward . . ." Sec. 319.26 Wis. Stats. But when the guardian has made adequate provision for the care and attention of his ward, a volunteer assuming to perform services or furnish supplies for the ward without knowledge or authority of the guardian cannot recover the value of such services or supplies.

"Employer-employe" and "indigent-poor relief" cases.—For information on these subjects see articles in this issue especially devoted to these cases.

Expenses of last illness.—Such expenses, being obligations contracted for during lifetime, must be presented as claims against the estate, unless they were expressly contracted for by someone other than the decedent. Such claim is a preferred claim (Sec. 313.16 Wis. Stats.) and is entitled to be paid in full prior to the payment of other obligations except those for funeral expenses.

Claims Against Decedents and Bankrupts

Decedents.—In the administration of an estate, the county court fixes a time during which creditors must present their claims. Notice is given by publication, and unless the claim "be filed within the time limited for that purpose, (it) shall forever be barred." Sec. 313.08 Wis. Stats. The time for filing can be extended, but not to exceed two years, upon proper application (showing cause therefor) filed with the court within sixty days after the expiration of the time set. Claim should be filed with the register in probate; should state fully the nature and amount of the claim, and the correctness of the items; and the amount should be sworn to before a notary public. County courts will furnish, upon request, the proper blanks to be used in filing the claim. Under an amendment to the law made by the 1939 legislature, a charge of 25¢ is made in Milwaukee county as a fee for filing any claim against the estate of a deceased. In counties other than Milwaukee, the clerk of county court is permitted to make a small charge, but in practice this is not done.

Claims for the expenses of the last sickness of the decedent, being preferred, may be ordered by the court to be paid in advance of general claims if the former have been presented within sixty days after the date of the original order. Sec. 313.03 (2) Wis. Stats.

Bankrupts.—Bankruptcy is a discharge of all debts which have been *listed* on schedules filed by the debtor (with certain exceptions). Claims, duly verified before a notary must be filed with the referee in bankruptcy ordinarily within six months after the first meeting of creditors. Creditors are given notice by mail (and by publication) of the first meeting, at which, if they desire, they can be present to question the debtor. A receiver is appointed to take over the assets, if there are any, and distribute them among the creditors.

A debtor who has received his final discharge in bankruptcy may still render himself liable for claims which have been proved and allowed. He may do so either by making a payment on the account to the creditor or by executing a written agreement to pay the account.

Matters Preliminary to Collection

Office records.—Collection of accounts may be simplified if in the first instance the doctor obtains the full name and address of the patient. He should insist upon the middle name or initial especially in the case of such common names as Johnson, Smith, etc. If treatment is for a minor, the name and address of the parents should be obtained, and if for a married woman, her husband's name, occupation, and employer. If children are not minors but are living at home, obtain the parent's name as well, since it may simplify the matter of locating the patient later. Physicians who make a practice of jotting down information regarding the patient's relatives, place of employment, etc., often find such informa-

tion invaluable in locating them later, and frequently use that information in determining the charges to be made.

Locating debtor.—When the debtor moves, his new address can often be obtained from his ex-landlord, or from neighbors. If he has a telephone, the telephone company will supply the new address. In some cities it is mandatory for trucking companies to report all removals which they handle, and an alphabetical list of such removals and new residences is kept at the police station. If gas or light is charged directly to the debtor at his new residence, the gas or electric companies will have information in their files which can often be obtained. If he owns personal property upon which a tax is levied, his address can be obtained at the assessor's office. If he owns a car, and it is licensed in his name, the Auto License Division at Madison will have his address. Each year an Automobile Directory is published by the Wright Directory Company, of Milwaukee, which aids in locating debtors who have moved. If a debtor is in the habit of buying on installment contracts, the contracts are usually filed with the register of deeds, and the address can be ascertained by checking the files, which are arranged alphabetically. Again, the importance in the first instance of obtaining the full name must be stressed, for, without that, the tracer is under a handicap in using any of the above methods.

The post office maintains, in connection with its registered mail service, a "tracing" service. For 20¢ in addition to the regular registration and return receipt fee, a letter will be delivered to the addressee personally, and none other, if he can be located, and the return receipt will show the address where the letter was delivered.

Informal Methods of Collection

Collection letters.—The attorney general has ruled that a letter stating that if a person does not pay, the sender will "take it out of his hide" constitutes an offense under the blackmail statute. Sec. 340.45 Wis. Stats. In effect, this statute provides that any person who shall maliciously threaten to accuse another of any *crime* or *offense* or *threaten to do injury to the person, property, business or profession of another*, with intent to extort money, may be prosecuted therefor. Collection letters should be dignified and confined to the purpose for which intended. Collection by postcard is forbidden by postal regulations.

Promissory notes.—Parties may, by contract, provide for interest rates of 10 per cent or less per year; 6 per cent is the legal rate if none other is specified in the note. Sec. 115.04 Wis. Stats.

A judgment note differs from an ordinary promissory note in that it provides a method of taking judgment including costs and attorney's fees, without service of process. It is ordinarily preferred, therefore, since it provides remedies that may be sought and enforced expeditiously.

Chattel mortgages.—Under some circumstances, it may be advisable to secure the note by obtaining from the debtor a chattel mortgage. The mortgage must describe accurately and in detail the property which it covers, and be filed with the register of deeds in the county where the property is situated if it is to protect the creditor against subsequent mortgages by the same debtor. Sec. 241.10 Wis. Stats. Chattel mortgages must be signed by the mortgagor and by his wife when exempt property is covered, and her signature witnessed by two persons. Sec. 241.08 Wis. Stats. They may be taken on any type of personal property. Such a mortgage is valid for three years, and can be extended for additional one-year periods by filing an affidavit with the register of deeds, describing the property, the prior mortgage, and the interest the mortgage holder has therein. Sec. 241.11 Wis. Stats. Provision is made for foreclosure and sale of the mortgaged property, upon proper notice to the mortgagor. Sec. 241.13, 241.135 Wis. Stats.

Wage assignments.—An assignment of wages by a married man of salary or wages which are exempt from garnishment is valid for only two months in advance. However, no assignment of such wages or salary is valid at all unless signed by his wife, if she be at the time a member of his family, in the presence of two disinterested witnesses. Sec. 241.09 Wis. Stats.

Wages to be earned under an employment not then in existence are not assignable. The law recognizes no assignment of future earnings unless such earnings are based on an existing contract of employment. Porte v. C. & N. W. Ry. Co., 162 Wis. 446 (1916).

Collection by Suit

Statute of limitations; malpractice.—Accounts for physicians' services become outlawed if six years have elapsed since the date of last payment, or since the last item of work was done, if no later payments were made. But, if the debtor "shall depart from and reside out of this state . . ." the statute of limitations is suspended during the time he is absent. Sec. 330.30 Wis. Stats.

It should be kept in mind that in order to avoid a possible counterclaim for malpractice, the physician should wait at least two years before bringing suit. (See the article in this issue relative to malpractice.) Under the provisions of section 330.19 (5), Wis. Stats., the complainant, if he has not already instituted action by summons and complaint in a personal injury action (including malpractice), must give notice within two years after the happening of the event which caused the damage claimed; and if such notice has not been given, his claim is barred.

Where suit is brought.—Actions involving less than $200 are commonly brought before a justice of the peace because the procedure there is usually more speedy, and the costs are less than in courts of record. Since a justice court is not a court of

record, the plaintiff or defendant, except persons under 21 years of age, may appear therein "by an attorney, agent or in person and conduct or defend any action." 301.20 Stats.

The jurisdiction of a justice of peace extends only to actions involving an amount of $200 or less, with certain exceptions, and only within the county where he is elected. The service of a justice court summons outside the county of issuance is ineffective as contrasted with a summons out of circuit court which is effective when served anywhere in the state. Therefore, if suit is against a nonresident of the county, it is usually forwarded to that county or brought in circuit court. Special courts, such as the Superior Court of Dane County and various municipal courts, have been created by the legislature from time to time, having such territorial jurisdiction as is granted by the act creating them.

Costs and fees in court actions.—Costs and fees vary, depending on the court in which action is brought and the type of action involved. In general, the costs are less in justice courts than in courts of record.

Justice court: Ordinarily if a summons is issued and the action settled thereupon without further proceedings the justice fees average $2. If the justice enters judgment by default, his fees average $3.50, but if the case is contested, the fees range from $5 up, depending upon the length of trial, number of witnesses, and amount of testimony (Chap. 307, Wis. Stats.).

The officer serving the summons is entitled to 10¢ per mile for travel, in addition to the fee set by statute for service. Sec. 60.55 (10) Wis. Stats. Witnesses are entitled to $2 a day plus 5¢ per mile travel. Sec. 325.05 Wis. Stats.

The costs and fees are added to the judgment, to which may be added attorney's fees in the amount set by statute, if the party claiming them is represented by an attorney, and the opposing party appeared to prosecute or defend the case. Sec. 307.02 (4) Wis. Stats.

Courts of record: Costs and fees differ in that the judge is on a salary basis, and collects no fee for his services. A filing fee and state tax amounting to $3 for the summons is provided. Sec. 59.42 Wis. Stats. Other costs depend upon the individual case.

Lien of judgment.—A judgment, or transcript thereof, when filed with the clerk of the circuit court of the county in which the debtor has real estate, is a lien on such real estate (except his homestead) as the debtor may have at the time of docketing or for ten years thereafter. Sec. 270.79 Wis. Stats.

It should be noted that a judgment rendered in justice court is not a lien on the debtor's property unless the judgment creditor has a transcript of it filed with the clerk of circuit court. Thereupon it "shall be deemed the judgment of the circuit court." Sec. 270.75 Wis. Stats. The justice is entitled to 25¢ for the transcript, and the clerk charges $1 to enter it.

While such judgments remain liens for only ten years, an action to collect the judgment can be brought at any time during the 20 years next after docketing. Actions to collect judgments of justice court (which have not been filed with the clerk of circuit court) are barred after a lapse of five years. Sec. 303.07 Wis. Stats.

Collection of Judgment

Introductory.—The fact that suit is resorted to in the enforcement of a claim is no assurance that the money will be collected, for many debtors are not in a position to pay many of their bills. Therefore, before resorting to suit, it is advisable to ascertain whether or not the debtor is in a position to pay the judgment, in case it is obtained.

Garnishment.—Garnishment proceedings can be instituted at the same time the original summons is issued or any time before final judgment, or later upon the judgment itself. Sec. 267.01 Wis. Stats. While commonly thought of as a method of reaching the wages paid to the debtor, the process of garnishment can be instituted to attach any property whatever, real or personal, due the debtor and in the hands of a third person, unless it is exempt. Various items reached in this manner are, money due on contract or salary, drafts or notes belonging to the defendant and other personal property. By statute the person who owes the debtor is liable as to debts due or to become due at the time the garnishee summons is served upon him, but the debt must be due absolutely and without depending upon any future contingency; for example, under a building contract under which nothing was due until completion of the building, garnishment was ineffective unless served after completion of the building. Mundt v. Shabow, (1904) 120 Wis. 303.

Executors and administrators are not subject to garnishment of moneys belonging to the estate they represent, at least not until their accounts are settled and they have been ordered by the court to pay over the respective shares to legatees or distributees. As a general proposition any property or fund in the custody of the law is immune from garnishment, as is property in transit by common carrier. Trustees, guardians, and assignees in bankruptcy are ordinarily not subject to garnishment of funds which they hold for the benefit of others. However, by section 272.30 Wis. Stats., real estate held in trust or for the use of another is liable for debts, judgments, execution and attachment against the person to whose use it is held.

Quasi garnishment.—Municipal corporations are not subject to ordinary garnishment proceedings, but the statute (Sec. 304.21) provides for what is known as quasi-garnishment of public employes whereby a judgment can be filed with the proper officer, and payment thereof made out of salary due the employe or such sums that may at any time become due the employe, subject, of course, to exemptions permitted by statute. The judgment should be

filed with the Secretary of State, in the case of state employes, otherwise with the clerk of the county, village, city, town, or school district. This procedure is more convenient than ordinary garnishment, in that costs are eliminated and certainty of payments is greater. The salary of a member of the legislature cannot be garnished. 20 Atty. Gen. 29.

Execution.—An execution cannot be issued until judgment is obtained. It is a written command issued by a court to the sheriff, directing him to execute the judgment of the court. In the ordinary case, it directs him "to satisfy the judgment out of the personal property of such debtor, and if sufficient personal property cannot be found, out of the real property belonging to him . . ." Sec. 272.05, Wis. Stats.

All of the property of the debtor, except that exempt by statute, is liable for his debts, that is, bank notes, money, bonds, stocks, equities in goods mortgaged or pledged and real estate. The officer conducting the sale must give twenty days notice of sale of personal property, and six weeks notice (by publication in addition to posting) in the case of real property. Sec. 272.29, .31 Wis. Stats.

Exemptions.—The statute sets out at length (Sec. 272.18) what property is immune from seizure by garnishment, execution, attachment, etc. to satisfy the debts of a person.

a. Earnings. The debtor is entitled to an exemption of 60% of his earnings, including the earnings contributed by minor children, but not less than $60 or more than $100 for the month preceding the issuance of the writ and not less than $180 or more than $300 for the preceding three months. In addition he is entitled to an extra $10 per month exemption for each child under 16 years dependent on him for support. This statute applies only to persons who have families dependent upon them for support. Sec. 272.18 (15) Wis. Stats. Thus most single people are excluded. Earnings include proceeds from the sale of crops, livestock, dairy products and other products grown or produced by a person to which his personal effort or that of his minor children has contributed.

b. Automobiles. Any automobile used or kept for the purpose of carrying on the debtor's trade or business, and not exceeding $400 in value, is exempt. If it is worth more than $400, it can be seized and sold, the $400 paid the debtor and the excess paid to the creditor. Sec. 272.18 (6) Wis. Stats.

c. Tools, etc. Tools, implements and stock in trade of a person used or kept for the purpose of carrying on his trade, not exceeding $200 in value, are exempt, (8) *Ibid.* In addition the statute (6) sets out various farm implements, to the value of $300; eight cows, ten swine, fifty chickens, two horses or mules and food for them for a year.

d. Household equipment. Household furniture not exceeding $200 in value is exempt, besides beds, stoves and wearing apparel. (5) *Ibid.*

e. Other personal property. Numerous specified articles are exempt, and the statute (Sec. 272.18) should be referred to before attempt is made to satisfy judgment by execution or otherwise.

f. Homestead exemption. The statute provides for a homestead exemption of not more than 40 acres of land, when used for agricultural purposes, and the dwelling thereon owned and occupied by the debtor, to the amount of $5,000. Sec. 272.20 Wis. Stats. If the land is in a village or city, or not used for agricultural purposes, the amount is limited to one-fourth of an acre including the dwelling thereon.

Attachment.—Attachment differs from execution in that it is available at the time an action is begun. It may be one of the methods of beginning an action. It consists in having the sheriff or constable seize property of the debtor and hold it until further direction of the court. It is available only under certain conditions set out in section 266.03, Wis. Stats., and is used primarily in cases where the debtor is about to move away or dispose of his property—situations in which it is essential to act quickly to tie up the property of the debtor. If, upon trial of the action, the plaintiff is awarded judgment, the property is sold as by execution, and the proceeds applied likewise. Sec. 266.23 Wis. Stats.

Before a warrant of attachment is issued, the plaintiff or somebody in his behalf must file with the court an affidavit stating that the defendant is indebted to the plaintiff in an amount over $5 in justice court or $50 in circuit court due on express or implied contract or judgment, and stating reasons why an attachment should issue. The court issues the warrant which can be served immediately and the goods attached. It should be kept in mind that the ordinary rules of exemption apply to attachment as well as garnishment and execution proceedings. It is important to note that the attachment only creates a lien which may be lost unless within a reasonable time after judgment the creditor issues execution. Special provision is made for sale of perishable property. Sec. 266.14 Wis. Stats.

Remedies supplementary to execution. — Sometimes it is suspected that the debtor has assets which are not exempt, but which have been concealed or for some reason have escaped execution. Supplementary proceedings in aid of execution can be invoked under Chap. 273, Wis. Stats., and an order issued by the court, or a judge of the county to which execution was issued (not a justice of peace), requiring the debtor to appear and "answer concerning his property." Sec. 273.03 Wis. Stats. Witnesses can be subpoenaed if necessary, and the debtor questioned upon oath as to his assets. If assets are discovered, not exempt, the court can order them applied toward satisfaction of the judgment. This procedure is available when execution is returned unsatisfied.

A receiver may be appointed to collect assets which may be due the debtor from others. Sec. 273.04 Wis. Stats.

Analysis of the Soldiers' and Sailors' Civil Relief Act

THE Soldiers' and Sailors' Civil Relief Act, 1940, although of greater interest to business men than physicians, has such far-reaching effects that a knowledge of its essential provisions is necessarily of interest to professional men and the public generally.

With a few scattered exceptions the act is a reenactment of the World War Act. Sometimes referred to as the Act of October 17, 1940, it protects all persons in military service from legal proceedings based on contractual obligations incurred prior to entering the service.

Its purpose, as stated by Congress, is to enable persons in military service to devote their entire energy to the defense needs of the nation. The act operates as a temporary suspension of legal proceedings but does not annul the obligation itself. Sec. 100.

From and after the date of the act it applies to those then in military service and to others as they enter the service. In no case does the act apply before induction into service. Its protection extends to those in the National Guard and reserve components of the army who have been ordered into active military service by the President under the act of August 27, 1940.

Section 604 of the act provides that its protection shall continue until the date of discharge from active service or death of the person while therein, or until the expiration date of the act, which is stated to be May 15, 1945; or, if the United States is then at war, it continues until six months after peace is proclaimed.

Sureties, endorsers, guarantors and the like may, in the discretion of the court, be extended the same relief as that granted to their principals. Sec. 103.

General Relief

In general the act provides, in section 200, that before any default judgment may be entered in any court, state or federal, whether a court of record or not, the plaintiff must file an affidavit setting forth facts showing that the defendant is not in military service, that he is in such service, or that the plaintiff is unable to determine the fact. Unless an affidavit is filed showing that the defendant is *not* in military service, no judgment shall be entered without a court order directing such entry. If the defendant is in military service no order directing entry of judgment shall be made until the court has appointed an attorney to represent the defendant. His acts, however, do not bind the defendant. Sec. 200 (3). Unless it appears affirmatively that the defendant is not in military service, the court may require as a condition to the entry of judgment, a bond to indemnify the defendant against any loss or damage should the judgment later be set aside in whole or in part. The court may make such further order as seems to it necessary to protect the rights of the defendant under this act. To get the judgment reconsidered, there must be a "meritorious or legal defense," and application must be made not later than ninety days after termination of service.

Bona fide purchasers for value under such a judgment which is subsequently vacated or modified, are, however, not affected. Sec. 200 (4).

The court may on its own motion, and must on request by or on behalf of a person in service, (a) stay any action or proceeding involving such a person, (b) stay the execution of any judgment or order entered against him and/or vacate or stay any attachment or garnishment of his assets, unless it believes that his ability, in case (a), to prosecute or to defend, or in case (b), to comply with the judgment or order entered or sought "is not materially affected by reason of his military service." Sec. 201 and 203.

There shall be no penalty where an action for noncompliance with any contract is stayed; and where a person fails to perform any obligation and a fine or penalty is incurred therefor, the court may, on such terms as may be just, relieve against the enforcement of the fine or penalty if it shall appear that the person was in military service when the penalty was incurred and thus, by reason of such service, his ability to pay or perform was materially impaired. Sec. 202.

The period of military service shall not be included in computing the running of statutes of limitation. Sec. 205.

Rent

Without leave of court granted upon application therefor, or granted in an action affecting the right of possession, no eviction shall be made during the period of military service as to any premises for which the agreed rent does not exceed $80 per month and which are occupied chiefly for dwelling purposes by the wife, children, or other dependents of a person in military service. Sec. 300. But the Secretaries of War, Navy and Treasury, as the case may be, are empowered to order a reasonable allotment of pay for rent. Sec. 300 (4).

In an interesting decision under the World War Act, a New York court held that where, because of the military service of the tenant, his landlord subleased the dwelling for less rental than that paid by the tenant, the difference was not an obligation of the tenant. States Realty Co. v. Greenfield (1920) 110 Misc. 220, 181 N. Y. S. 511.

Installment Sales

No person who, *prior to August 18, 1940*, has received a deposit or installment of the purchase price under a contract for the sale of real estate or personal property from one who after that payment

enters military service, may exercise any right or option under the contract to rescind or resume possession of the property except by court order. Sec. 301. The court may stay the proceedings, as provided in the act, or may make such other disposition of the case as may be equitable to conserve the interest of all parties to the contract. The court may order all or any part of the deposit or installment payments to be refunded to the purchaser before allowing the seller to resume possession. The court may adjust the payments to the financial ability of the person in military service, or it may arrange for the payments to be completed after the period of military service. Subsec. 4. The act provides that the purchaser and seller can change or cancel the contract on such terms as they may agree upon in writing. Similar relief is provided as to obligations originating *prior to August 18, 1940*, which are secured by mortgage, trust deed or other like security. Sec. 302.

No court shall deny or stay a legal proceeding to repossess a motor vehicle sold under installment contract unless the court shall find that 50 per cent or more of the purchase price has been paid. But, in any event, before allowing repossession, the court may require the plaintiff to post an indemnity bond. Sec. 303.

Real Estate Taxes

Section 500 forbids, in the absence of court proceedings, the forfeiture or sale of real estate "owned and occupied for dwelling, agricultural, or business purposes by a person in military service or his dependents at the commencement of his period of military service and still so occupied by his dependents or employees" for nonpayment of taxes, general or special, falling due during the period of service. To get this benefit, however, an application must be made to the collector of taxes by or on behalf of the person in service showing that his ability to pay is "materially affected" by reason of his service. Interest on past due taxes is restricted to 6 per cent and penalties are forbidden.

Relief under the act is extended to citizens of the United States who serve with the forces of any nation with which the United States may be allied in the prosecution of any war, provided they are honorably discharged and resume United States citizenship, or die in or as a result of such service. Sec. 512.

Income Taxes

With the exception of employes subject to the Federal Insurance Contribution Act, the collection of income taxes from any person in military service, whether the tax falls due prior to or during the service, shall be deferred for a maximum period of six months after termination of service, if his ability to pay the tax is materially impaired thereby. No interest or penalties may be charged for the extension, but the statute of limitations on actions to collect the tax shall also be suspended during military service and for nine months thereafter.

The validity of this law is established under the authority of the Congress to declare war and maintain armies. Hoffman v. Charlestown Bank (1918), 231 Mass. 324, 121 N. E. 15; Pierrard v. Hoch (1920), 970 re. 71, 191 P. 328.

Office Lease Provisions

THE negotiation and signing of leases is an almost universal periodic experience for the physician. If he will observe the precautions indicated below, he may avoid disagreeable experiences and monetary loss.

A lease is a special type of contract and once general negotiations have been completed, the desirable and prudent policy is to have an attorney draft the instrument itself. This will often prove a much more desirable policy than for the physician to read over hurriedly, and perhaps without full understanding, the printed provisions and rules of a "form" lease, which is generally drafted for the owner's protection rather than for that of the tenant.

Important Considerations

1. **Cancellation of lease by tenant for health or professional reasons.** The physician may wish to leave the community, in which he is practicing, for reasons of health or because of a more promising professional opportunity elsewhere. But because his office lease requires him to pay to the end of the term, and no other tenant can be readily procured, he may feel he cannot afford to leave.

Remedy: A clause giving the physician tenant the privilege of leaving for reasons of health, or for professional reasons, may be inserted in the lease with the consent of the owner. Ordinarily, such a provision requires the payment of some additional rent after the physician moves or gives notice of moving, say for thirty or sixty days ahead, so as to compensate the owner against possible vacancy for that period. The owner might reasonably require that in the event of removal for professional reasons, such change of location must not be merely to a place in the same locality, but some specified distance beyond the locality. This and details of notice and causes for moving should all be carefully agreed upon in such a provision.

2. **Cancellation of lease following death of physician.** The ordinary lease does not terminate on the death of the tenant but is expressly made binding on the tenant's heirs, personal representatives and assigns. This has the legal effect of binding the estate on rental and other obligations. It would seem wise to give the personal representative of a deceased physician (his administrator or executor) the option of limiting or terminating the rental lia-

bility of the estate whenever, in his judgment, this should be done.

Remedy: Following is proposed phrasing to carry out this suggeston:

It is mutually understood and agreed between the parties hereto, that in the event of death of the lessee during the term of this lease, his executors or administrators shall have the option of either terminating the lease or reducing its terms to a month to month rental basis, such privilege to be exercised within 60 days after the executors or administrators qualify as such in proper court proceedings.

Written notice of termination given to the lessor, or his agent, pursuant to the above agreement shall terminate all liability on the part of the lessee's estate, his administrators, executors or heirs, for rents to be paid for future occupancy of the premises beyond the 30 days next following the service of the notice.

Any option to renew contained in this lease may be exercised by the executors or administrators of the lessee at the time and in the same manner as provided for the lessee himself, but renewal of this lease will not be implied from any failure of the lessee's representatives to act hereunder.

3. **Decorating of premises.** Unless a lease otherwise provides, the owner may not be obligated to do any decorating of the exterior or interior of leased premises.

Remedy: Questions of decorating leased premises prior to occupancy and during the course of occupancy can easily be handled by appropriate provisions in the lease.

4. **Destruction of premises.** Leases frequently do not provide for the suspension of rent where fire or other casualty has rendered the premises partially or totally unfit for occupancy. Thus a situation may arise, in which the physician cannot continue to occupy the premises following a fire or other serious damage, or can, at best, only occupy them under great difficulty, and yet is compelled to continue full rent payments.

Remedy: The lease should provide that in the event the premises should become wholly untenantable by reason of casualty damage the physician either be immediately released from rental liability or be released following the expiration of a reasonable period required either for the rebuilding of the premises or for the substitution of office facilities in a form acceptable to him. Where premises have been made partially untenantable by reason of casualty damage the lease should provide for a proportionate abatement of rent. Thus if the premises are only 50 per cent usable, there should be a 50 per cent rental allowance until they are fully restored, but any percentage of nonuse over 50 per cent might well be considered as sufficient to excuse any rent payment.

5. **Heating and hot water facilities.** Unless a lease so specifies, the owner may not be obligated to furnish either heat or hot water, both of which are such essential items in a physician's office.

Remedy: Questions both of heating and the furnishing of hot water should be settled at the time negotiations are under way, and then should be carefully set out in the lease itself.

6. **Installations.** A physician may find that the premises he proposes to rent will require additional water and plumbing facilities, and also special air, gas and electric facilities. The three questions which arise in connection with such installations are: (1) Who has to pay for them initially? (2) Whose property do they become following installation? (3) Must they be removed or the premises restored at the termination of the lease? Such installations are generally costly, and these questions are therefore of substantial importance to the physician tenant.

Remedy: Wherever the plumbing, wiring, or other installations will permanently benefit the premises, the physician should endeavor to arrange that the owner pay so much of the installation cost as possible, and that he pay only the remainder. Wherever such installations are of such a character that they could be removed to other premises by the physician on the termination of his lease, he should reserve in himself the title to and right to remove such installations by terms of the lease itself. In the absence of such a provision, installations will ordinarily be regarded as affixed to the premises and, as such, a part of the real estate. This places title to such fixtures in the owner, and the tenant has no right to remove them on the expiration of the lease. Should the lease be for a period of only two or three years, a substantial investment would have been lost at the termination of that time should the physician be unable or unwilling to renew.

Where the tenant is permitted to remove such fixtures as he has installed, he would ordinarily be expected to restore the walls, floors and other affected parts of the premises to their original condition. This is a reasonable enough provision. Some leases, however, not only give the owner the legal title to such installed plumbing, wiring, etc., but also provide that at the owner's option the tenant may be required to restore the premises to their original condition on expiration of the lease, without being permitted to take away any of the fixtures for which he paid. The tenant should not permit such a provision in the lease.

7. **Military service.** A large number of physicians under 36 years of age may be called under the recently enacted Selective Service Act; still others will be called as members of the National Guard or as reservists. While the present extent of compulsory training is one year, the limit might be increased by subsequent legislation, and could be indeterminate should war be declared. The physician will be facing a serious enough loss by being away from his practice without having to pay the rental on his office during his period of service.

Remedy: It is doubtful whether the recently enacted Soldiers' and Sailors' Civil Relief Act permitting under certain conditions the suspension or

termination of leases by men in the service applies to offices required for professional purposes. It would be advisable on all leases made hereafter to insert a clause permitting the physician tenant either to cancel or go on a month to month basis should he be called into the military service of the government for training or for any other military purpose. It would seem equally advisable for those whose leases have some time to run to discuss the matter promptly with their landlords in an effort to work out some reasonable arrangement should the physician be called at a later date.

8. **Public liability coverage.** Many leases contain a clause under which the physician tenant assumes all liability which would normally accrue to the owner of the premises, as, for example, injury to a patient who might be hit by falling plaster in the physician's waiting room while keeping a professional appointment. The average public liability policy does not cover liability assumed under a contract by the tenant but, instead of this, commonly contains a clause substantially as follows:

> *"This policy does not apply to any liability assumed by the assured under any contract or agreement."*

The legal effect of such wording is that the physician is without protection under such a policy although he thinks he has coverage.

Remedy: First, examine the lease to see whether it contains such a provision; namely, that the physician tenant is responsible for any injury received by any person while on the leased premises, even though a defect in the building be its cause. Second, examine the public liability policy carefully. Third, if the policy contains an exclusion of any liability assumed by contract, the physician should then adopt one of the following two courses promptly: (1) arrange with the owner to change the lease provision under which he assumes such liability; (2) if he cannot have the lease modified, have the assumed liability covered by a specific endorsement to be added to the public liability policy.

9. **Renewal of lease.** No lease is automatically renewed unless it contains a specific renewal provision. All indications point to some increase in rental in the years immediately ahead, and the most practical way to hedge against increased rental is by timely provision in present leases or in leases which may hereafter be signed.

Remedy: If the physician is now under lease, it would be well for him to negotiate with the owner of the premises for a renewal option at this same rental. This provision could be added by mutual consent to the existing lease and would take effect on its expiration, if the option were exercised by the physician according to its terms. Ordinarily, such an option provides that the tenant may renew for an agreed period, at an agreed rental, by giving notice in writing of his intention to do so a certain number of days or months before the present lease expires. Those entering into leases hereafter would do well to include such renewal provisions.

10. **Repairs and upkeep.** The average responsible owner of office space will wish to keep up at least the exterior of the premises so as to prolong its life, minimize fire insurance rates and for other prudent reasons. Such owners are not necessarily willing to keep up the interior of the premises, however. Many leases go a step further and provide that all repairs of any nature which become necessary during the course of a lease are to be at the expense of the tenant. Thus, a physician might take over premises which were old or run down and have to replace such expensive items as the roof, floors, stairs, plumbing, heating plant and wiring during his occupancy.

Remedy: The prospective physician tenant should first make careful inspection of the premises he intends to lease, and come to immediate terms with the owner as to the condition in which they are to be put before he begins occupancy. He should then provide in the lease so far as possible that exterior repairs, such as painting, replacement of rotted boards or steps, or of the roof, be at the owner's expense. A still further provision might well be that repair or replacement of any substantial part of the premises during the lease was to be the obligation of the owner where such repair or replacement was due to ordinary wear and tear rather than to the negligence of the tenant. Still another prudent provision is that all structural repairs, which should include foundations, walls, floors, stairs, and roof, are to be the obligation of the owner rather than of the tenant. These provisions have particular importance where the physician is going to occupy old or outmoded premises.

11. **Subleasing.** Unless a lease makes provision for subleasing of the premises, the tenant has no rights whatever in this respect. A physician called into military service might find a highly desirable fellow physician to take over his practice, but he would be helpless in the matter unless the owner approved the subleasing. The same is true in the case of the physician who might wish to leave a community for reasons of health or because of an opportunity elsewhere.

Remedy: Provision should be made in the lease permitting subleasing of the premises after written notice to the owner. The provision permitting the physician to sublease should be as broad as possible, since he might not always be able to find a physician successor. At the very least it should permit him to sublease the premises to another medical practitioner.

The law on the subject of relation of landlord and tenant is a highly involved one and contains a large number of rules. It is thus difficult to generalize those rules, and the effort here made in that direction is intended to *indicate* problems which may quite commonly arise, together with suggested solutions. It must be borne in mind that the remedy in a given case may hinge on the particular facts, or even on a single fact, and that the suggestions above made will have general rather than specific application.

Important State Health Services, Laws and Rulings

Communicable Diseases

(See also vital information, pp. 1086–1088)

Contagious diseases, suspected cases, etc.—Conveyance, or permission for conveyance, of any person with a dangerous, communicable disease by public vehicle or to any public place, particularly as it may subject other persons to contracting such disease, shall be cause for arrest and punishment as provided in Sec. 143.10, Wis. Stat.

Conveyance between communities may be legitimately made with the consent of the health officers at points of departure and entrance, provided the public is protected.

Vaccination for smallpox.—When vaccination or exclusion from school is ordered in times of epidemic, with an actual case or cases in the community in a communicable form, the local board of health shall provide for the free vaccination of all children in any school district or part thereof during such outbreak, the expense to be borne by the district. Parents may employ physicians of their choice to perform such vaccinations and shall pay the expense incurred (Sec. 143.13 (3)).

Printed report forms.—The blanks to be used by physicians and others in reporting cases of dangerous communicable disease to the health officer are furnished by the State Board of Health to the local health officers for distribution among the physicians and other persons residing in their district.

Expense of cultures.—The expense of taking release cultures after recovery from diphtheria and the disinfection of persons and premises is a part of the expense of maintaining quarantine and must be paid by the town, village or city. The release cultures shall be made by or under the direction of the local board of health. Authorization of the local board must be obtained if physicians are to receive payment for taking release cultures.

Quarantine of physician.—If a physician's home is quarantined, he may remain as a member of the family and is then subject to the quarantine as other persons are, or he may live outside and visit his home in the capacity of a physican (Attorney General's Opinion.)

Reporting of cases.—A physician is required to report to the health officer in writing within twenty-four hours all cases of communicable disease (Sec. 143.04). (All suspicious cases must be reported and treated as positive until a correct diagnosis can be made. Any neglect or refusal of a physician or householder to report cases of communicable disease makes him liable to a severe fine.)

Quarantinable diseases.—Cerebrospinal meningitis (epidemic), cholera (Asiatic), diphtheria, infantile paralysis, plague, scarlet fever, smallpox, typhus fever, yellow fever.

Placardable diseases.—Chickenpox, influenza, leprosy, measles, German measles, typhoid fever, whooping cough.

Reportable only.—Erysipelas, lethargic encephalitis, mumps, ophthalmia neonatorum, pneumonia (lobar), trachoma, tuberculosis, malaria, amebic dysentery, epidemic sore throat, tularemia and undulant fever.

It is to be noted that malaria was made a reportable disease in Wisconsin in 1939.

Posting of list.—The official list of communicable diseases is required to be posted in every physician's office (also in every hospital). (Sec. 143.04.) The list is furnished free on cardboard by the State Board of Health.

Diagnosis.—In diagnosing communicable diseases, physicians shall use ordinary skill and bacteriological examination if that is of value in determining the true condition (Sec. 143.04).

Penalty.—For violation of any of the above laws, physicians are liable to fines ranging from $5 to $100, or imprisonment, or both; and for a second offense physicians are subject to suspension of their licenses to practice for one year except that licenses shall not be suspended for failure to post the list of communicable diseases (Sec. 143.04.11 and 143.11).

Privilege under quarantine.—Physicians are among the few individuals specified by law as permitted to enter premises quarantined for communicable disease. The expense of maintaining quarantine, including examinations and tests for disease carriers, provided this is done under direction of the local board of health, and the enforcement of isolation, shall be paid by the town, village or city, but the expense in treating communicable disease is not necessarily an obligation of the local board of health, and the local authorities cannot be held liable unless prior arrangement has been made with the physician (Sec. 143.05).

Tuberculosis.—Every physician is required to report within one week cases of tuberculosis in his care or under his observation. The report shall contain the name and address, age, sex, and occupation. The report shall be confidential to the extent that the name and address of the patient shall not be published by any newspaper or publication. The physician shall notify the health officer within twenty-four hours of the vacation of any place by death from tuberculosis or by removal of a consumptive (Sec. 143.06).

No person with tuberculosis of the lung or other part of the respiratory tract, or reasonably believed to be suffering from such disease shall be permitted to attend or frequent any school, except open-air schools, especially equipped for the purpose, until

(Continued on page 1089)

Vital Information Concerning the Prevention and Control of Communicable Diseases

Prepared by the Bureau of Communicable Diseases

WISCONSIN STATE BOARD OF HEALTH

For Public Health Nurses and Teachers

Those desiring more complete information upon the Wisconsin regulations on communicable diseases should request a copy of the pamphlet entitled, "The Prevention and Control of Communicable Diseases." Of interest to teachers is the pamphlet entitled, "Regulation and Recommendations Relating to the Sanitary Care of Schools."

Diseases	Early Signs and Symptoms	Incubation Periods	Periods of Communicability	Rules for School Attendance	Special Features
Diphtheria	The onset may be gradual or rapid. The early signs are those of fever and sore throat with grayish white patches on the throat, palate or tonsils. In laryngeal diphtheria there is continuous croupy cough. The glands of the neck near the angle of the jaw may be swollen. Later there may be profound prostration. Mild cases may be mistaken for ordinary sore throat.	2 to 5 days	While diphtheria organisms are present in secretions	Sick child must be excluded from school until two consecutive negative cultures, taken not less than 24 hours apart, are obtained from the nose and throat. Carriers must also conform to the same rule. No clinical case can return in less than 10 days. Children in the family with the patient may return to school after taking up their residence elsewhere for five days and obtaining negative cultures, the first to be taken at the time of removal and the second not earlier than the fourth day after removal. Children remaining in a quarantined home are released when quarantine is lifted and one negative culture of nose and throat and freedom from disease. Exposed children from other homes may return to school after a negative culture and freedom from symptoms of disease. Release cultures are to be taken by or under the direction of the local health officer, at the expense of the town, village or city.	A very serious disease varying greatly in its form and frequently escaping detection. Mild cases should be particularly sought after as they are fully as infectious as the more apparent ones. All children from nine months of age on should be immunized by injections of toxin antitoxin or toxoid. This causes permanent immunity to a high per cent. This should not be confused with antitoxin which is for treatment and immediate immunization after exposure. Daily inspection of children for fever, sore throat or croupy cough is recommended during the prevalence of the disease. Tests may reveal mild cases and carriers. Carriers are to be excluded and the health officer informed. The same person may have more than one attack of diphtheria.
German Measles	The malady is usually mild. The rash may be the first sign noticed. Ordinarily there is little signs of "cold in the head" as there is in measles. The eyes may be inflamed, while slight fever and slight sore throat may accompany the attack. Usually resemble mild measles or mild scarlet fever. Ordinarily appears in epidemics.	10 to 21 days	Most contagious during early part of disease.	Sick child cannot attend school. House is usually placarded for one week. Some local boards of health require two weeks' placarding. Other children in family may attend school but should be sent home on any signs of illness. See rule in "Prevention and Control of Communicable Diseases."	Precautions should not be neglected. May be confused with mild cases of measles or scarlet fever.
Influenza (Epidemic)	The onset usually is abrupt, with fever, chills, pain in the head, back and limbs as well as "a cold in the head." Lassitude or profound depression are characteristic symptoms. The epidemic character of the disease aids in making the diagnosis.	2 to 5 days	Unknown. Probably until four days after temperature is normal.	Sick child cannot attend school until 4 days after temperature becomes normal and abnormal manifestations have disappeared. Well children from infected homes can not attend school until temperature of last patient in home has been normal for four days.	An exceedingly infectious malady frequently followed by serious after-effects. The patient should be kept in a recumbent position until 4 days after the temperature has become normal or longer if necessary.
Measles	Begins like a "cold in the head," with running nose, sensitive or inflamed eyes, sneezing and fever. The rash consisting of small, irregular groups of dull-red, slightly raised spots, appears about the third day. The rash is usually first seen on the forehead and face, spreading rapidly over the entire body	7 to 18 days Usually 14 days	During period of catarrhal symptoms and while there are abnormal mucous membrane secretions.	Sick child can not attend school. Children from infected home who have had measles may attend school. Well children from infected homes who have not had measles can not attend school for 14 days from last exposure, dating such exposure from the beginning of the rash in last case in household. When measles is present in a community all children with the slightest indication of a cold or watery eyes should be excluded from school until recovery.	A malady which is infectious even before the rash appears. Complications such as bronchopneumonia, middle ear disease, weakness of the eyes and even tuberculosis may ensue. The after-effects are much more serious than the disease itself. The diagnosis can often be made early by detecting the Koplik spots in the mouth.

Chicken Pox	Usually occurs in children under 12 years of age. Onset usually gradual with mild fever. Fever symptoms may be lacking. The rash usually appears on the second day as small raised pimples which shortly become filled with clear fluid. Later scabs form. There may be successive crops of this rash, most marked on the trunk, up to the tenth day of the disease.	14 to 21 days	From the beginning of symptoms and as long as crusts are present on the skin.	Sick child can not attend school. Two weeks' placarding required at home. Well children from infected home may attend school, but should be sent home on first signs of illness.	Usually a mild disease with few after effects but readily transmitted. May be confused with the mild type of smallpox.
Mumps	The onset may be sudden or gradual, with slight fever, nausea. Swelling about the angle of the jaw and in front of the ear are the characteristic symptoms. The swelling may be painful.	4 to 25 days Usually 18 days	Two weeks after onset and one week after disappearance of swelling.	Sick child can not attend school for a least two weeks after onset of disease and not until one week after disappearance of swelling. No placarding required. Well children from infected homes may attend school if there is effective isolation of patient, but should be sent home on first signs of illness.	Because of the infectiousness of the disease attempts should be made to observe early symptoms after exposure and exclude immediately persons showing symptoms.
Scarlet Fever	The onset is often sudden. Sore throat, headache, fever and sometimes vomiting may be early symptoms. In the beginning of the disease the eyes are not watery or congested as in measles. Sore throat in mild cases may be the chief early symptom. The rash usually appears in less than 48 hours upon the neck and upper part of the chest and later extending to the limbs. It appears as a fine bright-red rash with evenly diffused spots. Later the surface layer of the skin usually peels and still later in the disease this peeling may show only on the hands and feet.	2 to 7 days Usually 3 or 4 days	At least four weeks from onset and while there are abnormal discharges or open sores.	SEE FOLLOWING PAGE	When the disease is present a daily inspection of the school children should be made for the purpose of detecting early cases. Sore throat, fever or other illness should result in the exclusion of a child from school until recovery. The disease is dangerous both during and after the attack. Complications are frequent. A small percentage of cases of scarlet fever do not have a distinct rash. Quite an additional number of cases have only a slight rash on some parts of the body, the rash disappearing within a few hours. The failure to recognize these obscure cases is undoubtedly responsible for the occurrence of many additional cases.
Smallpox	The onset is apt to be sudden, with fever, headache and backache which may last three or four days. The rash appears after a decline in temperature and is usually first noticed about the wrists and face. It consists first of small red spots, which quickly become elevated and hard like shot to the touch. These later develop into pustules and crusts.	8 to 21 days Usually 14 days	From first symptoms to disappearance of all scabs and crusts.	Sick child cannot attend school or leave home until all crusts or scales have fallen off Exposed children who were vaccinated immediately after exposure may return to school. With the written consent of the health officer, they may live in the quarantined home, but must not come in contact with the patient. Exposed children, who are not vaccinated, must be quarantined.	Section 143.13 of the Statutes. Upon the occurrence of smallpox in a municipality it becomes incumbent upon the local board of health to prohibit the attendance at school of children and teachers for a period of 14 days unless they can produce evidence of a recent or successful vaccination. Vaccination is a nearly perfect preventive against smallpox and dependence should be placed upon this measure in combating smallpox.
Whooping Cough	Symptoms are a cold, sneezing, coughing. This fails to ameliorate and after a variable period of a few days to two weeks the characteristic whoop may begin.	Within 14 days	During catarrhal stages and during first weeks of characteristic whoop	Sick child must be excluded from school at least 6 weeks after onset of the cold and while in whooping stage. Well children from same home may attend school, but must be excluded upon slightest sign of cold or cough.	Whooping cough is especially infectious during its early stages. The disease is often fatal to children under five years of age and occasionally to older individuals, and may cause prolonged debility at all ages.

SCABIES OR ITCH

An infectious eruption found most frequently on the forearm and between the fingers but may involve the entire body. Ordinarily it takes the form of small, scattered, red spots among which there may be some watery vesicles or pustules. Marked itching characterizes the disease which is of a chronic nature unless treated. The infected child should sleep alone and be kept away from others until cured. During treatment the underclothing and bed linen should be frequently changed and boiled to kill the parasite to prevent reinfecting the body. Whenever the disease occurs in a family all children in the family should be inspected for evidences of it. The disease is non-febrile

PEDICULOSIS OR LICE

Light gray insects. Lay eggs or "nits" in the hair especially at the nape of the neck and about the ears. Symptoms are irritation and itching of the scalp.

The treatment of this condition is accomplished by thorough application, to the scalp and hair, of a mixture of equal parts of olive oil or sweet oil and kerosene. The next day the hair should be thoroughly washed with vinegar to remove the nits or ova of the louse. If by chance all the nits or ova are not removed by the first application the treatment should be repeated

EXCLUSION FROM SCHOOL

Teachers should send home at once any pupil with a severe cough, a severe cold, itch, lice or other vermin or any contagious skin disease; also children who are filthy in body or clothing or who have any dangerous contagous or infectious disease. [See rule 17, Prevention and control of communicable diseases. In all suspected cases of any communicable disease, both parents and health officer should be informed. (Rule 17)]

IMPETIGO "CONTAGIOUS SORE"

Sores which are at first watery vesicles or pustules and which soon form loose scales and crusts. Appear on face and sometimes hands—pea or finger-nail size—may be one or several. Adjacent sores may unite into "patches". Child should use separate towels. The disease is contagious. Exclude child until sores have disappeared. (Rule 17)

Vital Information Concerning the Prevention and Control of Communicable Diseases—Continued

Scarlet Fever Control Rules for Wisconsin

On July 18, 1939, the State Board of Health adopted new rules governing the control of scarlet fever. These rules, published in mid-August, became effective in mid-September, and supersede all previous rules governing the disease.

Here are the rules.

1. *Quarantine.* The patient, persons in the household, and premises shall be placed under quarantine except as specified in the following paragraphs.

2. *Length of Quarantine.* Persons with mild cases, when so designated by a physician, may, on approval of the health officer, be released in twenty-one (21) days from the date of report. In all other cases, quarantine shall be maintained for at least twenty-eight (28) days from date of report and while the patient has acutely enlarged or suppurative cervical glands, ear discharges, or inflammatory or catarrhal conditions of the nose and throat caused by the disease, and until all indications of communicability have ceased. With the consent of the health officer cases requiring a long quarantine may be released in ten (10) weeks, provided proper precautions can be taken by the patient. When the quarantine is removed prior to six weeks' time, the patient shall not attend school or come in contact with groups of children or handle foodstuffs to be consumed by others in less than six weeks from the beginning of quarantine. Children on the premises who have remained well may be liberated and attend school upon removal of quarantine. The patient should remain isolated from all other children in the home until the six weeks' period is completed.

3. *Wage Earning Contacts.* A special *written* permit may be granted by the health officer to adult wage earners or providers of the family needs living in quarantined homes, allowing them to enter and leave the quarantined premises only for the purpose of attending their work. Such wage earners or providers must be eighteen years of age or over. Such permit shall *not* be granted if the wage earner or provider of the family needs is a food handler or the work requires handling of milk, milk utensils, or milk products. A permit shall *not* be granted if the wage earner or provider of the family needs comes into close contact with the patient while in the quarantined home or in contact with groups of children while at work. Such persons shall be subject to examination for scarlet fever at such periods as required by the health officer.

4. *Other Family Contacts.* Well persons in the quarantined household may be permitted to leave after cleansing and having clean or disinfected clothing, and shall not again enter the premises until the removal of quarantine. Such persons shall also be subject to examination for scarlet fever at such periods as required by the health officer. Children so moving shall remain in isolation for seven (7) days after removal and if they then have no symptoms of scarlet fever may return to school provided they continue to reside in a separate building apart from the quarantined household. Upon removal of a scarlet fever patient to a hospital or elsewhere the premises shall be disinfected and the well children of the household shall remain isolated for seven days after removal of patient.

5. *Contacts Outside Family.* Children outside of the family intimately exposed to scarlet fever shall be isolated for seven days from date of exposure. Teachers and other adults intimately exposed in place of residence shall not attend school or associate with groups of children for seven days after exposure.

6. *Diagnosis by Desquamation.* Desquamation characteristic of scarlet fever shall be considered evidence of scarlet fever in lack of other probable diagnosis. The health officer shall determine the date of onset of disease as near as possible and shall impose the usual period of quarantine from that date, which shall never be less than fourteen (14) days and in no case shall a child be permitted to attend school in less than six weeks from probable onset.

7. *Examinations, Violations, etc.* Persons holding permits and others who have been exposed to scarlet fever shall be examined for scarlet fever at such periods as are required by the health officer. Permits may be cancelled for violation or non-compliance with the regulations. Where it is apparent to the health officer that isolation is ineffective quarantine may be established for the period required.

8. *Disinfection.* All articles which have been in contact with a patient and all articles soiled with the discharges of the patient shall be concurrently disinfected. Terminal disinfection by chemical means and thorough cleaning of premises shall be carried out before quarantine is removed.

the health officer of the municipality where the school is situated furnishes a written certificate stating that the individual is free from a communicable form of tuberculosis. Such certificate shall only be issued after thorough examination by a licensed physician in a manner satisfactory to the State Board of Health.

Venereal disease.—All physicians and certain institutions are required to report directly to the State Board of Health all persons with venereal disease in a communicable state who come to them for treatment (Sec. 143.07).

A printed form, furnished by the State Board of Health, is used for reporting. This report is to be by age, sex, conjugal condition and name of the disease, but *not* the name of the patient although a serial number may be given in each case. Printed instructions for the patient are attached to this report blank and are required to be given to him. Secrecy is imposed upon the State Board (Sec. 143.07).

The State Board of Health requires that the source of infection be inquired into and reported back to the Board for the purpose of investigation. All persons having a venereal disease must remain under treatment until the disease is no longer communicable. Discontinuance of treatment may be the cause for commitment to an institution until the disease is no longer communicable. Investigation in cases not under treatment may be made by an officer of the State Board of Health, or, when so directed by the State Board of Health, by any local health officer who is a physician (Sec. 143.07.2, 4, 5).

Drugs commonly used for treatment of syphilis, both arsenicals and heavy metals, are furnished by the State Board of Health on request to physicians in indigent or near-indigent cases where little or no compensation is involved. Physicians having patients unable to pay for treatment for venereal disease may assign such individuals for treatment to state clinics.

When a patient refuses treatment the physician shall notify the State Board of Health, giving particulars, to enable the Board to act, and, if necessary, to have the person committed for treatment. In counties of over 250,000 population, the county board may designate the county institution where such commitments may be made. Such persons may be summoned before any court of record or a warrant may be issued for them (Sec. 143.07.5).

When a physician has reported a case of venereal disease to the State Board of Health, all questions regarding the presence of the disease and the date from which treatment was neglected shall not be regarded as privileged information when the patient or physician is called upon to testify to the facts before any court of record (Sec. 143.07.7).

Physicians shall be furnished free of charge with the results of examinations for the diagnosis of gonorrhea made by any state laboratory, and of examinations of blood or secretions for the diagnosis of syphilis from the Wisconsin Psychiatric Institute (Sec. 143.07.10).

Any city or county may require that persons convicted of acts involving moral turpitude shall undergo a medical examination for the presence of a venereal disease.

No physician or health officer shall issue a certificate of freedom for any person except those certificates required by law for marriage licenses and those required by local ordinances to be issued to local health officers. No person shall carry or exhibit such certificates to other persons, or show, for immoral purposes, venereal disease reports from any laboratory.

All cases of venereal disease shall be regarded as communicable until the following requirements have been met: Until open sores are healed; until satisfactory care and treatment has been given pregnant women with syphilis, females who have given birth to a syphilitic child, syphilitic persons at any stage of the disease who reasonable evidence indicates are promiscuous in sexual relations and are a menace to others, and persons with early syphilis not adequately treated.

Physician protected from liability.—A physician who reports to the State Board of Health the name of a person afflicted with a venereal disease on account of such person not continuing treatments until the disease is no longer communicable will be protected from liability, if the facts justify his action. (Attorney General's Opinion.)

Infant blindness.—The attending physician (or midwife) is required to use a 1 per cent silver nitrate solution in the eyes of newborn babies. For the prevention of ophthalmia neonatorum the State Board of Health is required to supply the solution free to every physician (and midwife), put up in proper containers and distributed to health officers for delivery to practitioners.

When ophthalmia neonatorum appears in any newborn babe not attended by a physician or midwife and the case is reported, as required, to the health officer, a competent physician shall be employed by the municipality to examine and treat the infant as directed in the instructions accompanying the solution. The penalty for violation of any part of this law is a fine up to $100 (Sec. 146.01).

Vital Statistics

Registration with local registrars.—Upon locating for the practice of medicine, physicians are required to register their name, address and occupation with the local registrar of vital statistics, and by him be supplied with the laws, rules and regulations for the enforcement of the vital statistics law (Sec. 69.17).

Registration of births.—Physicians shall file within five days certificates of births attended by them. Such reports are to be made to the local registrar of the district in which the births occur. All particulars shall be given in the space provided. All bills or charges for professional services rendered

in connection with confinements are declared unlawful and need not be paid until the birth certificate, properly filled out, is filed as provided in Sec. 69.26.

Illegitimate births.—In the case of a child born out of wedlock, the physician shall not fill in the name of the supposed father until legal proceedings shall have adjudged the paternity of the child. (Sec. 69.28.21).

Chapter 524, Laws of 1939, provides that a new certificate shall be made out in cases of illegitimate birth when the parents are subsequently married or when the child is subsequently adopted. This new certificate is to contain no reference to the illegitimacy or adoption. The original certificate is to be filed and may not be obtained thereafter except on court order.

Certificate of birth before child is named.—When a certificate of birth is presented without the given name, the local registrar shall make out and deliver to the parents a special blank for the supplemental report of such given name (Sec. 69.30).

Stillbirths; registration required.—In stillbirths the attending physician shall register the children as births and deaths, with the explanatory word "stillbirth." The medical certificate shall state the cause of stillbirth, if known, whether a premature birth; and, if born prematurely, the period of uterogestation in months, if known. (Sec. 69.32).

Report of congenital deformities.—Physicians shall report to the State Board of Health within twenty-four hours after birth, any child with a deformity or physical defect, such report to be separate from and in addition to the birth certificate, and shall explain fully the nature of the defect. They may also make suggestions and recommendations as to the care, treatment or correction of such deformities or defects (Sec. 69.29). Such reports are turned over to the Crippled Children Division for the purpose of follow-up work.

Registration of deaths.—Special article on this subject to appear in forthcoming issue.

Miscellaneous Services and Rulings

State Laboratory of Hygiene.—Physicians shall be furnished free of charge with results of laboratory analyses of specimens sent for determining diagnosis of disease (Sec. 36.225). These laboratories include the central laboratory in Madison, branch laboratory at Rhinelander, and cooperative laboratories at Oshkosh, Green Bay, Superior, Beloit, Kenosha, Wausau, Sheboygan and La Crosse.

The materials which are examined in these laboratories are sputum for tubercle bacilli; swabs for diphtheria bacilli and other organisms; pus for gonococci and other organisms; central nervous systems of dogs and other animals for Negri bodies diagnostic of rabies; spinal fluid for meningococci and other organisms; materials in suspected cases of anthrax, glanders and actinomycosis; blood, feces and urine for the diagnosis of typhoid and paratyphoid fever (blood only for tularemia and undulating fever) or to detect carriers of these germs; and chemical and bacteriological examination of water to detect its fitness for drinking purposes. The examination of tissue in suspected cases of malignancy is done only in the laboratory in Madison, and only in those cases wherein the patients are unable to pay a special fee. Such tests are made free for physicians, and the facilities of the laboratories are urged upon the physicians of Wisconsin in the effort to detect and combat communicable disease. Pneumonia typing is now a valuable service offered by the laboratories.

State biological products.—Under the law, local boards of health are required, under the direction of the State Board of Health, to furnish antitoxin free of charge to indigents suffering from communicable diseases. When a case of smallpox occurs in a community, the local board of health shall offer free vaccination of school children in that community.

Laboratory examination for venereal disease.—The state laboratory of hygiene and branch and cooperative laboratories shall make microscopical examinations for the diagnosis of gonorrhea, and the Psychiatric Institute the necessary examinations of blood or secretions for the diagnosis of syphilis, for any physician in the state, without charge.

Venereal disease, indigents. — The county is required to pay for the care and treatment of indigent persons afflicted with a venereal disease (Attorney General's Opinion).

The county is responsible for one-half of the per capita cost for the care and treatment of indigents committed to state institutions for the treatment of venereal disease (Sec. 143.07 (6)).

Drugs limited to prescriptions.—The sale on prescription or recommendation of any drug for the treatment of venereal diseases may be done only through written prescription issued by a licensed physician (Sec. 143.07.11).

Information.—Section 146.15 requires that physicians of mining, manufacturing and other companies, and certain officials, shall, upon request, furnish to the State Board of Health any information touching the public health, and for refusal shall forfeit $10.

Corpses, duty of physician.—Disinterred corpses are declared dangerous to health and may not be transported unless authorized by a permit from the health officer, showing name, age, place, and medical attendant. Local health officers shall refuse permit when the cause of death is given as heart failure

unless the physician in charge states that the cause was not diphtheria (Sec. 155.01).

Industrial illness, occupational diseases.—Every medical practitioner shall report to the State Board of Health cases of poisoning from lead, phosphorus, arsenic or mercury or their compounds, or compressed air illness contracted in employment, giving patients' names and addresses and the type of diseases suspected. A fine of $10 is applicable for failure to comply with this section (Sec. 69.49).

Prenatal letter service. — This service of the Bureau of Maternal and Child Health of the State Board of Health consists of a series of letters directed toward educating expectant mothers to seek routine prenatal care early and to keep themselves under the care of their physicians throughout pregnancy. Matters of diet and general hygiene are discussed as well as those warning signs that should promptly be reported to the physician.

When the name of an expectant mother is received, she is sent the first group of letters covering the month of pregnancy she is then in, the booklet "Prenatal Care," and the wall card on health habits in pregnancy. With this group of letters a letter to the expectant father is included which urges his cooperation in providing adequate medical supervision for his wife. At approximately the same time each following month an additional letter goes to the mother. With the eighth letter the mother also receives the booklet, "Infant Care," the diet and development cards for the first year, and leaflets on "Sun Baths and Cod Liver Oil" and "Establishing Good Food Habits." The ninth letter is followed by one sent six weeks later urging the mother to visit her physician for a postnatal examination and to keep her baby under medical supervision.

A sample set of this material is available to any physician upon request and slips are provided for his convenience in enrolling expectant mothers for this letter service.

Film service.—The State Board of Health has available to physicians for both lay and professional presentation, films on various subjects some of which may be obtained without rental charge upon request.

Incubator service. — Fifty incubators (and more are being added) are available for general use throughout the state. These may be secured by contacting the local county nurse. This service is amplified by means of demonstrations in cases of premature delivery in the home.

Lecture service.—A lecture for medical societies on the subject of "New Methods in Obstetrics" is available through the Bureau of Maternal and Child Health. This lecture is delivered by William Keettel, M. D., whose services are furnished by that Bureau.

Maternity homes.—No license shall be issued unless the State Board of Health is satisfied that the physical equipment of the place to be used as a maternity hospital is adequate for the proper care of mothers and infants. The State Board of Health may revoke the license of any maternity hospital if the persons licensed to conduct the same shall have violated any provision of sections 48.43 to 48.46 or any of the rules and regulations of the State Board of Health issued thereunder or the provisions of such license. Violation of the above regulations shall be punished by a fine of not less than $10 nor more than $500, or by imprisonment in the county jail for not more than one year, and said term of imprisonment in case of an association or corporation may be imposed upon its officers who participated in said violation.

Rulings on Public Health Administration

Disagreement on diagnosis.—If two or more physicians disagree upon a diagnosis of a communicable disease, the health officer, if a layman, should select a physician to make a diagnosis for him and handle the case accordingly.

Tests for quarantine release.—If tests are required for release from quarantine, the tests are to be made by the health officer or some one designated by him, either a physician, nurse, or an individual especially trained to make such tests. Such material should be sent at once to a state laboratory.

Swabs, when accepted.—Swabbings taken by the attending physician will not be accepted in releasing from quarantine, unless the attending physician has been authorized by the health officer to make such swabbings. If so authorized, they are accepted.

Qualification as joint health officer.—A physician can legally qualify as health officer of two adjoining towns, although he may live in another jurisdiction. (Attorney General's Opinion).

Tuberculous patients; admission to sanatoria.—Application and report of examining physician blanks, required for entrance to the county sanatoria, are provided by each institution. The state sanatorium is located at Statesan, Wisconsin, and twenty county sanatoria are located conveniently throughout the State where patients suffering from tuberculosis may be admitted for care and treatment. Admission to sanatoria is by order of the county judge only, including the finding by him as to ability of the patient to pay.

The Bureau of Maternal and Child Health of the State Board of Health has available and will supply single copies to Wisconsin physicians of the following booklets and pamphlets: "Maternal Care" and "Maternal Care Complications," by F. L. Adair, M. D., and "The Appraisal of the Newborn Infant," by Ethel C. Dunham, M. D.

Medical Witnesses and Expert Testimony

NEVER before has medical testimony assumed such importance as in recent years. Formerly many medical men asserted that they did not care to be drawn into litigation, but it is now next to impossible for an active general practitioner, much less for a specialist, to escape at least some appearances either before courts or such administrative tribunals as the industrial commission. Medical testimony is important and frequently even of controlling weight in cases involving mental competence as, for example, lunacy, guardianship, and will proceedings. It is also of paramount importance in the field of industrial accidents and disease, while the increased use of the automobile has in itself given rise to an almost independent branch of jurisprudence and with it problems of forensic medicine.

The subject falls logically into two divisions. The first is that of the ordinary nonexpert medical witness, and the second is that of expert or opinion testimony ordinarily offered only by specialists. A number of observations may be made with equal applicability to both classes of medical witnesses.

One of the first questions which arises in the mind of the physician is his duty with respect to offering testimony either in a nonexpert or expert capacity before a court or administrative tribunal. It may seem an elaboration of the obvious to recall that the physician is first of all a citizen and as such an integral part of his community; that the courts, and such bodies as an industrial commission "are part of the machinery of his government." The average physician undoubtedly has a professional duty to assist with his training and knowledge, a judge or public administrator who may have need of his judgment. This is quite apart from any legal requirement.

On the purely legal side it is well settled in Wisconsin, as elsewhere, that a doctor must obey the order of a court or other properly authorized public official to appear and offer testimony in a given case. This order customarily takes the form of a subpoena and the doctor must obey a subpoena, just as any other citizen, under penalty of contempt.

Nonexpert Testimony

Generally speaking, the testimony of an ordinary practitioner appearing in a nonexpert capacity is much more limited in character than that of his brother physician who has qualified and is appearing as an expert. Ordinarily, the general practitioner may testify only to what he has observed in the case of a given patient and a given disease. He is limited to the facts which have come from his own professional diagnosis and observation, although even the nonexpert medical witness generally is given a latitude unknown among nonexpert witnesses in other fields, that of prognosis. This undoubtedly is judicial recognition of the high general training of the medical profession, and of the further fact that a physician is as greatly concerned with prognosis as with diagnosis and treatment. No medical witness whether nonexpert or expert should ever volunteer an answer to a question to which he does not know the answer. Neither should he fall into the trap of giving an opinion which exceeds either his training or his observation.

While no conscientious physician will venture before any tribunal unprepared, unless summoned without notice, it may be said as a general proposition that exhaustive preliminary research either in the laboratory or in medical literature is not be expected in the case of the nonexpert witness. It is ordinarily enough that he review his case notes, hospital record or other memoranda, and limit himself to what they show, together with such other findings as are within his personal knowledge.

Neither the nonexpert nor expert medical witness may employ medical texts to supplement his testimony. It is permissible in some states to quote medical authorities who agree with the findings of the witness, or for the witness to state that his diagnosis or prognosis is supported by a certain medical writer. It is undoubtedly advisable for any physician before going into court to have in mind at least the leading literature of the particular field in which he is going to testify, unless it is so highly limited that only a specialist could be expected to know it. By having that minimum preparation he may be saved the embarrassment of seeming unfamiliar with outstanding medical literature, which admission is frequently elicited by the attorney for the other side for the sole purpose of casting doubt on the validity of the witness' otherwise competent testimony.

The question of the compensation of the nonexpert witness rather commonly arises, and is a matter which should be settled, wherever possible, in advance of the physician's appearance before a tribunal. As a matter of strict law neither a nonexpert nor expert witness is, merely in his capacity of witness, entitled to more than the statutory fee, which in Wisconsin is $2.50 for a court of record. If a nonexpert witness is to receive more compensation than is given him by law, this should be arranged for with the person requesting such witness' public attendance and testimony. It is reasonable for the nonexpert general practitioner to ask compensation, within the financial limits of the party on whose behalf he appears, which will roughly compensate such witness for the loss of time and inconvenience to which he is put.

Care should be observed, however, in the interests of the physician's own integrity, and in the best interests of justice, that the physician at no point acquire a monetary interest in a given piece of litiga-

tion which might even unconsciously color his judgment. While no exception can be taken to a physician's testifying as favorably as he conscientiously can for the particular side on which he is called, the ethical physician will be careful never to have a vested interest in the outcome of a pending cause.

Both the nonexpert and expert medical witness must remember at all times that section 325.21 of the Wisconsin Statutes makes privileged any information which the physician may have acquired in attending any patient in a professional capacity. (See the article on page 1051 of this issue on the subject of "Privilege.") The only exceptions are: homicide trials, lunacy inquiries, civil or criminal malpractice actions against the physician, and express waiver of the privilege either by the patient, or in the event of the latter's death or disability, by such person's personal representative.

Expert Testimony

The general subject of expert or opinion testimony is the peculiar province of the expert witness. In the words of a recent author on jurisprudence: "An Expert Witness is one who has made the subject upon which he gives his opinion, a matter of particular study, practice or observation, and who has a special knowledge on the subject, which must be recognized in law as a distinct department of human knowledge and endeavor."

The Wisconsin Supreme Court, in a leading case on the subject, states: "*The more difficult field is entered when we approach the question of calling upon men of exceptional experience and qualifications to give their opinion as the result either of facts which they observe or from an hypothetical statement of facts. This is the real field of expert evidence. It is there that the expert can testify and the nonexpert cannot.*"

At the outset care should be taken to distinguish two senses in which the word "expert" is commonly used. As the Wisconsin Supreme Court has wisely observed "Much of the testimony of a so-called expert is in no wise different in character from that of any other witness." Frequently both attorneys and courts seem to regard *all physicians* as expert in the general field of treatment of human illness by comparison with laymen. It is true that all physicians are expert in the sense of being peculiarly and specially educated in the general subject of medicine. The situation is further complicated by decisions holding that, although a physician is not a technical specialist in a particular branch of medical science, he may testify as an expert, where, assuming hypothetical statements of fact to be true, he can express an opinion, satisfactory to himself without further study, as to a question of science pertaining to a special field.

Perhaps the principal difference between an expert and nonexpert medical witness, is that the former's testimony is far less circumscribed. The nonexpert is limited to matters within his personal observation and knowledge. The nonexpert may not ordinarily express an opinion, as differentiated from facts, except in the field of prognosis. The expert, on the other hand, may, in addition to stating observations and other facts within his personal knowledge, give opinions based on two sources other than professional observation of the party as to whom he is offering testimony. These are: (1) Information gained by him from testimony which the expert heard in court; (2) Information assumed by a hypothetical question propounded to him.

Whereas the general practitioner is ordinarily qualified with the statement that he has been admitted to the practice of medicine in Wisconsin, and that he has practiced for a given number of years, the expert must be qualified far more carefully. He should make statements as to his postgraduate studies, his research, any writings, any teaching or other positions, any specialized experience or practice, the fact that he has had opportunity to observe an exceptionally large number of cases, or anything else designed to set him apart from the general practitioner or non-specialist. The careful qualifying of an expert witness is highly important for its psychological qualities in impressing a tribunal or a jury, as well as for the further reason that it lays the foundation for the degree of weight to be attached to the testimony subsequently offered.

As has already been stated it is equally the duty of the expert as well as the nonexpert medical witness to respond to a properly issued summons to appear before a tribunal. This rather fundamental difference may be noted however, between the expert and nonexpert witness. The essence of the nonexpert's testimony is *facts* and *actual observation*, whereas the essence of the expert's testimony is *opinion* based upon a special skill and experience even in the absence of observation of a given case. A nonexpert witness would undoubtedly be in contempt of court for refusing to tell what he *knew* in a given case especially where the patient has waived the statutory privilege, but a court cannot compel an expert to have an *opinion* concerning a situation of which he has not personal knowledge, or as to which he has made no observations. However, if the expert does have an opinion, whether previously familiar with the case then before the tribunal, or not, he is under legal duty to offer that opinion if so requested. The question whether a physician after being in attendance on a patient may be compelled to testify as an expert may be answered in the affirmative if such physician can qualify as a technical expert on the particular ailment or disability involved in a given case. In other words, actual observation should, if anything, lend greater strength and credibility to a medical expert's testimony than a theoretical response to a hypothetical question.

Still another important difference between the nonexpert and expert witness lies in the amount of preparation prior to appearance before the tribunal. While the nonexpert witness will ordinarily not be expected to do more than review his case

notes and tell what he has observed, and what he knows as a result of such observation, the expert cannot stop at this point. By the very reason of his being an expert he is supposed to know much better than his nonexpert fellow physician the medical literature, the laboratory aspects, and the technical medical side of the particular point in issue. This presupposes preparation of a most careful character. Wherever possible, it will presuppose examination of the patient and a personal knowledge of the history of the case. This is not always possible in the case of adverse parties, or of a deceased, and it is for this reason, among others, that opinion evidence and the hypothetical question are so commonly employed.

Much has been written, a good deal of it critically, of the hypothetical question which is so commonly employed in the examination of expert witnesses. Such a question has been defined as "one which states and assumes as true certain probative facts appearing in evidence, and asks the opinion of the witness thereon as to some ultimate fact in issue." Hypothetical questions should be so formulated as not to invade the fact-finding province of the jury; they need not be limited to undisputed facts, but should not contain facts which are not before the tribunal. Such questions should cover sufficient ground to justify invoking expert opinion, should be technically as accurate as possible and should never be unfair or misleading.

Hypothetical questions have frequently found disfavor both with courts and the medical profession, but they serve a perfectly legitimate function, namely that of assuming a given medical or other factual situation, thereby filling gaps in the witness' own opportunities for observation and diagnosis in a given instance. Such questions also serve as a check on the facts, and further, afford a basis for prognosis which is frequently all-important in personal injury or industrial cases.

Where it happens that an expert witness has likewise treated the patient he is competent not only to testify on the basis of what he has seen and knows of the specific case, but also to give opinion evidence and to answer hypothetical questions.

The question of compensation very properly arises in connection with expert medical witnesses. By very reason of the fact that such witnesses are expert they customarily command higher remuneration than do general practitioners; they commonly travel a longer distance; they are expected to prepare much more fully and comprehensively than nonexperts. Skill, special knowledge, exceptional or even unique experience, all distinguish them from the ordinary medical witness. All of these marks of the expert may properly be weighed in considering what constitutes fair compensation for the testimony of such a person. Warning cannot be too strongly sounded, however, that while an expert should have compensation which is fair under all the circumstances, he should not be given a monetary interest in the outcome of the litigation, nor should his compensation in any way depend upon the character or emphasis of his testimony. His compensation must always have professional rather than commercial limits. Whenever the facts are otherwise the result in too many cases will tend to be at least an unconscious coloring of such expert's testimony because of his almost proprietary interest in the consequences of what he says. Both legal and medical literature are replete with warnings against luring the expert witness from a professional plane and making him what is for all practical purposes almost a proponent in the litigation. An expert who so acts reflects discredit on himself, on his profession and on the entire practice of permitting the offering of opinion evidence.

No better guide is available for the almost religious observance of both nonexpert and expert medical witnesses than the following decalogue, brought to the attention of the medical profession by Dr. A. I. Rosenberger, Milwaukee, who in turn has ascribed it to Dr. W. E. Grove, Milwaukee:

1. Examine your case thoroughly and repeatedly so that you know what you are talking about. Know your facts well. They must be incontrovertible. The opinion you form from these facts is your own, but must be arrived at honestly.

2. Testify slowly, clearly, simply, and in language that the layman can understand. Forget your Latin medical terms. You are obliged to talk down to the level of intelligence in the jury box in order to get your facts across.

3. Stick to the unvarnished truth. If you do not, your statements will strike back at you like a boomerang.

4. Do not become partisan or assume a proprietary interest in the legal proceedings, for if you do, it will diminish your value in the eyes of the court and the jury.

5. Maintain your dignity and do not advise or consult with an attorney in the courtroom, but sit far away from him. The attorney should prepare his case before he goes into court.

6. You are not required to answer by "yes" or "no" an involved question if such answer places you in the position of the man who was asked, "Have you stopped beating your wife?" Your "yes" would be a lie and your "no" a prevarication.

7. If a long, involved, hypothetical question is to be propounded to you, request that it be given to you in writing before you are put on the stand so that you may thoroughly study it and not embarrass your attorney by your answer.

8. Refuse to answer any question which puts you into some other field of medicine than your own. You may always say, "I cannot qualify."

9. Do not allow an attorney of the blustering, bull-dozing type to anger you or "get your goat." The purpose of this line of questioning is to throw you off guard.

10. Remember that at times the most valuable words in the English language are, "I do not know."

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« « « EDITORIALS » » »

The Platform of the American Medical Association

1. The establishment of an agency of federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy

Today the medical and health functions of the United States are divided among a multiplicity of departments, bureaus and federal agencies. Thus, the United States Public Health Service is in the Federal Security Agency; the Children's Bureau in the Department of Labor; the Food and Drug Administration in the Department of Agriculture; the Veterans' Administration and many other medical functions are separate bureaus of the government. The WPA, CCC, and PWA are concerned with a similarity of efforts in the field of preventive medicine. The Federal Works Administration and the Federal Housing Administration also have some medical functions.

Since 1875, the American Medical Association has urged the establishment of a single agency in the federal government under which all such functions could be correlated in the interest of efficiency, the avoidance of duplication, and a saving of vast sums of money. Such a federal health agency, with a secretary in the cabinet, or a commission of five or seven members, including competent physicians, would be able to administer the medical and health affairs of the government with far more efficiency than is now done.

2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need

The physicians of the United States have given freely of their time and of their funds for the care of the sick. Their contributions to free medical service amount to at least $1,000,000 a day. The physicians of this country have urged that every person needing

medical care be provided with such care. They have urged also the allotment of funds for campaigns against maternal mortality, against venereal disease, and for the investigation and control of cancer. The medical profession does not oppose appropriations by Congress of funds for medical purposes. It feels, however, that in many instances states have sought aid and appropriations for such functions, without any actual need on the part of the state, in order to secure such federal funds as might be available. It has also been impossible, under present technics, to meet actual needs which might exist in certain states with low per capita incomes, with needs far beyond those of the wealthier states, in which vast sums are spent.

It is proposed here simply that Congress make available such funds as can be made available for health purposes; that these funds be administered by the federal health agency, mentioned in the first plank of this platform, and that the funds be allotted on proof of actual need to the federal health agency, when that need is for the prevention of disease, for the promotion of health, or for the care of the sick.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility

Obviously if federal funds are made available to the individual states for the purposes mentioned in the second plank of this platform, there might well be a lessened tendency in many communities to devote the community's funds for the purpose, and, in effect, to demand that the federal government take over the problem of the care of the sick. Hence, it is suggested that communities do their utmost to meet such needs with funds locally available before bringing their need to the federal health agency, and that the federal health agency determine whether or not the community has done its utmost to meet such needs before allotting federal funds for the purpose.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration

The medical profession is not static. It wishes to extend preventive medical service to all of the people within the funds available for such a purpose. Obviously, this will require not only a federal health agency which may make suggestions and initiate plans, but also a mechanism in each community for the actual expansion of preventive medical service and for the proper expenditure of funds developed both locally and federally. In the development of new legislation, such mechanism may be suitably outlined.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration

The medical profession does not yield to any other group in this country in its desire to extend medical care to all those unable to provide themselves with medical service. The American Medical Association through its House of Delegates has already recognized the possible existence of a small group of persons able to provide themselves with the necessities of life commonly recognized as standard in their own communities, but not capable of meeting a medical emergency. It is recognized, however, that only persons of the same community fully familiar with the circumstances can determine the number of people who come properly under such classification and that only persons in actual contact with such instances are capable of administering suitably and efficiently the medical care that may be required. Hence it is the platform of the American Medical Association that medical care be provided for the indigent and the medically indigent in every community but that local funds be first utilized and that local agencies determine the nature of the need and control the expenditure of such funds as may be developed either in the community or by the federal government.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established

In the so-called National Health Program it is asserted that one-half the counties of the United States are without suitable hospitals, and vast sums are requested for the building of new hospitals. In contrast, reputable agencies within the medical profession assert that there are only 13 counties more than 30 miles removed from a suitable hospital and that in 8 of those 13 counties there are 5 persons per square mile. In the United States today the percentage of hospital beds per 1,000 of population is higher than that of any other comparable population in the world. This fact is completely ignored by those who would indulge in a program for the building of great numbers of new hospitals.

Moreover, it seems to be taken for granted that hospital building has languished in recent years, whereas considerable numbers of hospitals have been built with federal funds by various state agencies and also by the PWA, the WPA and the Federal Works Administration.

Analyses may indicate that in many instances such hospitals were built without adequate study as to the need which existed or as to the possible efficient functioning once they were erected. Moreover, there is evidence that in recent years many of the hospitals of the United States known as nonprofit voluntary hospitals have had a considerable lack of occupancy, owing no doubt to the financial situation in considerable part. It seems logical to suggest then that such federal funds as may be available be utilized in providing the needy sick with hospitalization in these well established existing institutions before any attempt is made to indulge in a vast building program with new hospitals. In this point of view the American College of Surgeons, the American Hospital Association, the Catholic Hospital Association, the Protestant Hospital Association and practically every other interested voluntary body agree.

Again it has been argued that the demands for medical care in some sections of the country might require the importation of considerable numbers of physicians or the transportation of numbers of physicians in the areas in which they now are to other areas. In this connection it would seem to be obvious that a change in the economic status of the communities concerned would result promptly in the presence of physicians who might be seeking locations. The utilization of existing qualified facilities would be far more economical than any attempt to develop new facilities.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability

In the United States today our sickness and death rates are lower than those of any great country in the world. This fact was recognized by the President of the United States when he sent the National Health Program to the Congress for careful study. The President emphasized that a low death rate may not mean much to a man who happens to be dying at the time of tuberculosis. The medical profession recognizes the importance of doing everything possible to prevent every unnecessary death. At the same time it has not been established by any available evidence that a change in the system of medical practice which would substitute salaried government doctors for the private practitioner or which would make the private practitioner subject to the control of public officials would in any way lower sickness and death rates.

There exists, of course, the fact that some persons are unable to obtain medical service in the circumstances in which they live and that others, surrounded by good facilities, do not have the funds available to secure such services. Obviously, here again, there is the question of economics as the basis of the difficulty and perhaps lack of organization in distribution of medical service and a failure to utilize new methods for the distribution of costs which might improve the situation.

The medical profession has approved prepayment plans to cover the costs of hospitalization and also prepayment plans on a cash-indemnity basis for meeting the costs of medical care. It continues, however, to feel that the development of the private practice of medicine which has taken place in this country has led to higher standards of medical practice and of medical service than are elsewhere available and that the maintenance of the quality of the service is fundamental in any health program.

8. Expansion of public health and medical services consistent with the American system of democracy

Careful study of the history of the development of medical care in various nations of the world leads to the inevitable conclusion that the introduction of methods such as compulsory sickness insurance, state medicine and similar technics results in a trend toward communism or totalitarianism and away from democracy as the established form of government. The intensification of dependence of the individual on the state for the provision of the necessities of life tends to make the individual more and more the creature of the state rather than to make the state the servant of the citizen. Great leaders of American thought have repeatedly emphasized the fact that liberty is too great a price to pay for security. George Washington said, "He who seeks security through surrender of liberty loses both." Benjamin Franklin said, "They that can give up essential liberty to obtain a little temporary safety deserve neither liberty nor safety."

In these times when the maintenance of the American democracy seems to be the most important objective for all the people of this country, the people may well consider whether some of the plans and programs that have been offered for changing the nature of medical service are not in effect the first step toward an abandonment of the self-reliance, free will and personal responsibility that must be the basis of a democratic system of government.

Expediting Insurance Claims by Cooperation With Insurance Companies*

By MR. R. G. KNUTSON

Former Member of the Industrial Commission of Wisconsin; Now Assistant Claims Manager in Charge of Compensation, Hardware Mutual Casualty Insurance Company
Stevens Point

THOSE of us familiar with the fundamental principles of workmen's compensation realize that insurance carriers are expected to meet their obligations under the law with the least possible delay. The Wisconsin Industrial Commission is to be complimented for its persistency in promoting compliance with this statutory provision. To accomplish a decent compliance with this all-important provision of the compensation law, the commission has a right to expect the undivided cooperation of insurance carriers, employers who are subject to the compensation law, and the members of the medical profession. During the period from January to June, 1940, 83.3 per cent of all compensation claimants in the state received their first payment of compensation within fifteen days—as compared with 61.9 per cent for a like period ending February, 1938. These statistics of the commission clearly demonstrate that improvement can be had, and the results should act as a stimulus for still greater improvement with respect to an additional increase in the number of compensation claimants receiving their compensation checks within the statutory period.

* Presented at the 99th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1940.

Insurance carriers are somewhat handicapped with respect to further improvement in the present record by failure to secure the proper cooperation of certain employers and members of the medical profession in connection with submitting the necessary reports and information to us. We realize full well that physicians have no responsibility for the delinquency in delayed reports on the part of employers. However, substantially all compensation claimants require some form of medical treatment and, if we can secure the sincere cooperation of the members of this group in submitting their reports promptly, such action will accomplish a wholesome influence in overcoming most delinquencies in delayed reports on the part of employers. Whenever an employe receives an injury in the course of his employment, he is usually referred to a doctor at once. In the large majority of these cases, the doctor has substantially as prompt notice of the injury as the employer. If physicians will assume this situation to be true, they will better appreciate the importance of your making a prompt report to the insurance carrier and thereby overcoming any delinquency on the part of the employer. If a blank medical report is not available, it is suggested that certain information be submitted to the carrier on any ordinary stationery. This report should contain a brief history of what the injured person was doing at the time of the injury, the name of the employer for whom he was working when injured, the date of the accident, and the date when disability began, a brief history of the nature and extent of the injury, and the probable extent of temporary total disability in either days or weeks. This information would, in many instances, permit the insurance carrier to start payment of compensation without waiting for a report from the employer. The probable extent of temporary total disability is essential for the purpose of permitting us to determine whether or not payment for the first three days' waiting period can be included in the original compensation check.

With reference to the history of the injury, it is usually only necessary to say that John Doe injured his finger or hand while operating a punch press for, say, the Smith Wagon Company. Naturally in those cases where an honest question can be raised with reference to the injury having been sustained in the course of the employment, or whether the disability is the result of an alleged injury or hazard growing out of the employment, then it is essential that we secure a more detailed history regarding the alleged occurrence resulting in the disability. In this type of case, we usually prefer to have one of our own representatives make a detailed investigation of the pertinent facts and then confer with the attending physician for the purpose of obtaining the benefit of his scientific knowledge in determining whether or not the disability is the result of the alleged injury or exposure.

The insurance carriers have attempted to cooperate with the commission in connection with the use of a universal medical report. The thought has often occurred to me that probably a committee of this group could be of considerable assistance in offering their suggestions when this report is again revised. In those claims involving medical treatment only, or varying periods of temporary total disability, it is essential that we and the commission have a definite statement from the attending doctor that no permanent disability has resulted from the injury. In *those cases involving amputations of certain members of the body, it is respectfully requested that the doctors make more use of the diagrams contained on the back of the commission's form A-16.** It is surprising how infrequently doctors use the diagrams in indicating the exact point of amputation of a body member.

Quite frequently confusion arises in attempting to determine from a medical report which digit of a hand has been injured or the joints involved by amputation or other injury. For the purpose of uniformity, it is suggested that you use the language contained in the compensation law. The digits are referred to as the thumb, index finger, middle finger, ring finger, and little finger. The joints of these digits are referred to as the distal, middle, and proximal. When the doctors use the foregoing terms in their reports, it is

* See p. 1045 of this issue.

much easier to convince the claimant as to the amount of compensation which he should receive by referring him to the minor injury schedule contained in the compensation law.

In substantially all of these cases a time arrives when it is felt that the injured has sufficiently recovered to permit his returning to work. In this connection you can readily appreciate that we are largely dependent upon the advice of the attending physician. *We find altogether too frequently that attending physicians will report the end of a healing period to the insurance carrier but fail to impress this fact upon the injured party.* When the doctors fail to discuss this important matter with the claimant, we experience difficulty in attempting to convince the claimant that he has recovered sufficiently so as to permit his returning to work. We sincerely believe that a little extra time spent with the injured in discussing this situation with him would eliminate many delays, criticisms, and dissatisfaction.

There are several cases in which it is a foregone conclusion that the injured persons will suffer a relatively permanent disability before they are able to return to work. In most of these cases, it is desirable that the injured persons return to some type of suitable employment for some period of time before attempting to estimate the ultimate permanent disability. Dependent upon circumstances, it may be desirable that an individual work for a period ranging anywhere from two months to a year before his condition becomes stationary. Where such circumstances exist, we believe that considerable misunderstanding could be eliminated if the doctor were to encourage a continuation of work with the assurance that the claimant would not jeopardize his rights under the law by so doing.

The Industrial Commission has expended considerable time and effort in attempting to establish more uniformity in connection with the estimating of permanent disabilities. In this connection I desire to call attention to pages 110 and 111 in its pamphlet containing the compensation law with the amendments to October 22, 1939. For the purpose of avoiding delay in this respect, I again refer to the commission's form A-16. In the questions listed thereon it will be noted that the commission is insistent upon having certain definite information in addition to the doctor's estimate of the percentage of permanent impairment. The commission is desirous of knowing the exact extent to which motion is limited from normal, the amount of weakness resulting from the injury, the malpositions of the bones following serious fractures, and any other definite pathology which enters into the doctor's estimate of his percentage of permanent impairment.

In further connection with the question of permanent disability, I desire to extend my compliments to the officers of the State Medical Society in their efforts to advise their members with respect to the proper method of evaluating permanent disabilities under compensation. In this connection, the Society has published and sent to its membership a pamphlet dated June 15, 1940†, containing information regarding the proper estimating of permanent disability. The information contained in this pamphlet gives the views of the Industrial Commission on this important factor of compensation and should be of considerable value to those members of the Society who have not had substantial experience in the rating of permanent disabilities. For those not fully familiar with this important subject, may I call attention to the desirability of noting the copy of this pamphlet† and thoroughly studying its content. Familiarity with this constructive information will further tend to expedite the handling of compensation claims and avoid much expensive and unnecessary litigation in connection with securing the final determination of many cases.

An attempt has been made to point out a few of the contingencies which result in delayed payments of compensation. It is my sincere belief that adherence to the suggestions contained herein will result in better satisfied compensation claimants, less work on the part of all of us through receiving the proper medical information originally, and a reduction in expense by compensation claimants in avoiding considerable unnecessary litigation.

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† Reproduced, with a few alterations, on pp. 1039 to 1047 of this issue.

. . . . THE PRESIDENT'S PAGE . . . .

Wisconsin Hospital Association

IT HAS been called to my attention by hospital people that any physician in good standing is eligible to membership in the Wisconsin Hospital Association, which is a component of the American Hospital Association.

The meetings of this Association offer a splendid opportunity for discussion of the physician's relationship to hospital control without personal elements entering into the problem. The policies of hospitals have largely been crystallized over a period of years at these meetings, which have been excellent from the angle of a free exchange of ideas on hospital management. However, the physician has been entirely in the background in the set-up. I believe some of the difficulties we find ourselves in today might not have presented themselves if we were more active in the Wisconsin Hospital Association and its parent organization.

With these thoughts in mind, I wish the membership to give serious thought as individuals to becoming members of the Wisconsin Hospital Association; fifty such memberships would be a help. If just the secretaries of the county societies (usually holdover positions) would belong, it would be a step in the right direction. Perhaps a state secretaries' meeting could be held on the same day as the meeting of the Wisconsin Hospital Association. This is a new thought, yet well worth your consideration in staff rooms and county groups.

A Merry Christmas and a Happy New Year to you all!

Ralph P. Sproule

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. Donne F. Gosin, Green Bay, President
Mrs. J. S. Supernaw, Madison, President-Elect
Mrs. Samuel A. Montgomery, LaCrosse, Vice-President
Mrs. Harry A. Keenan, Stoughton, Recording Secretary
Mrs. Robert W. Kispert, Green Bay, Corresponding Secretary
Mrs. Edwin P. Bickler, Milwaukee, Treasurer

COMMITTEE CHAIRMEN

Archives—
Mrs. Dana B. Dana, Kewaunee
Convention—
Mrs. Arnold S. Jackson, Madison
Finance—
Mrs. Robert E. Fitzgerald, Wauwatosa
Hygeia—
Mrs. Gerald H. Friedman, Milwaukee
Organization—
Mrs. Ernest S. Schmidt, Green Bay
Philanthropic—
Mrs. Henry E. Twohig, Fond du Lac
Press and Publicity—
Mrs. Arnold H. Barr, Port Washington
Program—
Mrs. Maynard H. Fuller, Green Bay
Public Relations—
Mrs. Reuben H. Bitter, Oshkosh
National Exhibit (special committee)—
Mrs. E. Lee Lochen, Waukesha
Circulation of Bulletin (special committee)—
Mrs. Robert E. McDonald, Milwaukee

Christmas Greetings to Auxiliary Members

Again we are approaching the beautiful Christmastide and the New Year. We Americans, who have so much for which to be grateful, should rejoice, but should temper our joy with a thought and a prayer for those ravaged with the horrors of war.

For each member of the Woman's Auxiliary to the State Medical Society of Wisconsin I wish an abundance of health, happiness, and peace. May you as helpers continue to strive for the aims and ideals as set forth by the members of the medical profession. Be loyal, be willing, and take an active part.

A Merry Christmas to you all and a special greeting to the newest member of our family,—the Woman's Auxiliary to the Ashland–Bayfield–Iron County Medical Society.

MRS. DONNE F. GOSIN,
President.

Program—Health Education

By MRS. MAYNARD H. FULLER
Green Bay

"SERVICES Proffered Involve Obligation"—this is the theme offered by the program chairman of the Woman's Auxiliary to the American Medical Association for the year 1940–1941.

While the objectives of the auxiliary and its basic purposes remain the same, its possibilities and activities enlarge each year proportionately to the ever-increasing accomplishments of our county auxiliaries. The chief problem seems to be that of recommending a program that may prove helpful to all county auxiliaries in creating a year of planned activities sufficiently interesting *to attract new members, increase attendance at meetings, and stimulate interest in the educational work* as suggested by the State Medical Society. These objectives may be attained by adopting a program to include activities definitely applicable to local needs and to include the active participation of as many individual members as possible.

Projects

What, then, are some of the most important projects that every county auxiliary should follow?

1. Increase the sale and distribution of Hygeia.

2. Undertake an active year's work in public relations.

3. Develop an alert, interested legislative committee which is ready to act on advice from your county medical society on any health legislation problems that enlist the active interest of the organized medical profession; keep auxiliary membership informed on legislative work by distributing bulletins previously edited by representatives of your county medical society. Our national chairman on legislation (Mrs. Arthur A. Herold, 1166 Louisiana Avenue, Shreveport, Louisiana) will send needed material on request.

4. Give serious thought to the social side of our organization and plan meetings throughout the year designed to promote a friendly relationship among the members.

5. Follow developments of medicomilitary preparedness (see special department in the Journal of the American Medical Association).

6. Incorporate in your programs throughout the year some talks on health topics, as well as on problems that confront the medical profession today, such as socio-economic subjects, health insurance, and unwise extension of health activities.

Conduct of Meetings

The conduct of meetings is bound to have an important influence on the effectiveness of your program. These suggestions are offered to help you in the above objectives and projects:

1. Invite the secretary and the president of the county medical society to address the auxiliary annually at the first fall meeting. This will make the individual members conscious of their parent organization, but of greater importance, it will serve to make the medical organization more aware of the service possibilities inherent in the auxiliary.

2. Have all the committee chairmen report on their activities at each meeting. This will serve to make the individual members more alert to auxiliary interests. Committee chairmen not called upon to report periodically soon have nothing to report.

3. The president should allot time and suggest previously notified speakers to open the discussion following most presentations. This usually increases interest.

Work Projects

Selecting projects that are definitely applicable to local needs is, of course, the responsibility of the county program chairman and the president. Mrs. V. E. Holcombe, national auxiliary president, in her talk at our state convention advised us to stress periodic health examinations for children and also prenatal examinations. She suggested that each doctor's wife sponsor one health program.

Dr. Nathan B. Van Etten, president of the American Medical Association, urges every auxiliary member to see that her husband does not become careless in his responsibilities toward community health programs. He says, "He must be stimulated to take a new attitude and *direct* these programs—and *direct* the public health nurse and the welfare worker in all their activities. If he assumes this attitude locally he will find his true place in civic affairs. . . I seriously look to the Woman's Auxiliary of the American Medical Association to change this manner of the care of those who are really public dependents and spread this load over the community so that no doctor is exploited by so-called welfare organizations. . . The effect of your work upon your special educational projects is sure to be felt. *I am convinced that the place for this work is the small community and that the sum of such efforts will change the national picture.*"

The distribution of posters announcing the American Medical Association's radio program, "Doctors at Work" every Wednesday at 9:30 p. m., C. S. T., National Broadcasting Company (Blue Network), November 13, 1940—June 4, 1941, is suggested by our national program chairman, Mrs. Walter F. Donaldson. Sets of these posters are being mailed to all county auxiliary presidents.

Many ideas for local projects may be gleaned from the auxiliary section of the Journal of the American Medical Association and from the county news items in this *Journal.* In the last year, for example, such diversified local projects as the following were reported in our county news items: a Child Health Week Campaign, a toy loan project, an orthopedic clinic, layettes for needy patients, and social hygiene lectures.

Study Projects

The following topics for program study material are suggested:

1. How the auxiliary may best extend its influence and support the aims of the disease control committees of its medical society.

2. The menace of socialized medicine to the present high quality of medical service in the United States.

3. Continued interest in cancer, tuberculosis, syphilis, maternal and child health, and other health topics.

4. Books and reading material on medical history and progress (October Bulletin).

5. The platform of the American Medical Association (October Bulletin).

6. Current events in medicine—five or ten-minute talks at each meeting.

7. Facts about the American Medical Association (October Bulletin).

8. Resolutions adopted at annual meeting (October Bulletin).

9. Messages of state and national officers as published in this Journal and in the Bulletin. Our state president, Mrs. Donne F. Gosin, has requested that we devote five minutes of each county meeting to this purpose.

10. Reports made by the trustees and the scientific councils to the House of Delegates of the American Medical Association and the addresses of the officers of the American Medical Association.

11. Daylight saving, a new Wisconsin project explained in a separate article on page 1106.

12. Discussion of the American Medical Association's radio programs, "Doctors at Work," previously mentioned here.

In conclusion, may I quote again from Dr. Nathan B. Van Etten's address* at our national convention: "Does your state need more hospitals in new locations? Does your state need more beds in existing hospitals? Does your state need more laboratories? Does your state need more ambulances? Does your state need, and can it support, more doctors? Does your state need more specialists? Does your state need more public health nurses? Does your state need more welfare workers? Does the health program in your state need financial help through federal agencies from the general tax pool? Have you read the Wagner Health Bill S. 1620? Have you read the Mead Bill? Have you read the Pfeiffer Bill? Have you read the modified Wagner–George Bill? Have you studied the President's plan? Do you know the American Medical Association's platform by heart? And do you understand its implications? Do you know Surgeon General Parran's plan for a crusade against syphilis? Does the medical service in your state serve your citizens adequately?"

And again quoting from Mrs. Holcombe, "If the auxiliary is to serve in its fullest capacity it must be self-educated. Can you, as an auxiliary member answer these questions intelligently? Would it not be well for you to build your year's progress around these thought-provoking questions?"

* Printed in full in October Bulletin.

HONORS FOR WISCONSIN

This seems a good time to remind you that Mrs. George H. Ewell of Madison, who was our state press and publicity chairman in 1938–1939, is now national chairman and the new editor of the Bulletin of the Woman's Auxiliary to the American Medical Association. We told you in November about the excellent material to be found in the October issue of this quarterly magazine which has undergone changes in size, compactness, and general make-up under Mrs. Ewell's editorship. You have heard from Mrs. Holcombe, our national president, that the major aim of the auxiliary this year is to increase the Bulletin's circulation. Five thousand subscribers, approximately one-fourth of the membership, is the goal.

Are one-fourth of the members of your auxiliary subscribing? County presidents and county committee chairmen: do you subscribe to and make use of the Bulletin in your work? Let us make Mrs. Ewell proud of her own state's record. Send your $1 now to:

Mrs. H. E. Christenberry, Highland Drive, Knoxville, Tennessee (or)
Mrs. R. E. McDonald, 4960 North Ardmore Avenue, Milwaukee, Wisconsin.
The next issue will be out in January.

Public Relations

By MRS. REUBEN H. BITTER
Oshkosh

WITH the barrage of propaganda that is being hurled at the medical profession through books, movies, radio and press, the public relations work of our auxiliary cannot be stressed too strongly. Be positive you know just what the term "public relations" means. Its correct definition is often misunderstood, and if we are to function most efficiently we must know the why, and the what, of this important work.

Excellent articles on this subject have been written and fine talks given, and from these I should like to point out some of the essentials.

1. It is understood, of course, that every auxiliary should have a public relations chairman. I cannot emphasize too much the necessity of careful selection of this individual for it is she who must make contacts with lay groups. This requires tact, fairness, and a certain amount of aggressiveness.

2. Familiarize yourself with the sources of able speakers, and be sure that the man you place is the proper one for that particular group. Many an excellent speaker has wasted valuable time, and many a group has been bored because the public relations chairman failed to ascertain just what type of address was wanted. In our zeal to assist in planning a meeting, we must not forget that we are not the only ones concerned, but that a lay group has initiated a program in which we are allowed to participate.

3. All organizations are interested in public health, although their interests may be stronger in some phases than in others. Offer your services in an effort to be helpful along the lines in which their interests lie.

4. Confer with the members of your county medical advisory committee before placing any speaker for they know the men best trained to be of utmost service. Very often, and I stress this particularly, your county medical society has speakers who are capable of stimulating outside interest in a given subject.

5. Organizations which are constantly seeking speakers are the P. T. A.'s and church societies. These are usually receptive and represent fine groups before which to have good health talks.

Courtesy contacts are easily and pleasantly made by planning a public relations tea, to which presidents or other officials from local women's organizations may be invited. For such a meeting it is a good idea to have a speaker trained to discuss such subjects as "The Attitude of Medicine on the National Health Program" or "The Wagner Health Bill." However, do not let this one meeting a year suffice. Remember that your work is never finished and that there are times innumerable when opportunity will knock and you, as auxiliary members, will have the opportunity to be health standard bearers.

It is most essential to have the approval of your medical advisory board before any program is attempted so that appropriate speakers are placed before each group. The American Medical Association, Wisconsin Anti-Tuberculosis Association, American Society for the Control of Cancer, State Board of Health, and our own Mr. J. G. Crownhart, secretary of the State Medical Society of Wisconsin, are a few of the outstanding sources of help in placing trained speakers.

Auxiliary members should not speak before lay groups on medical economics or specific health problems, but they should nevertheless be well informed on all phases of public health and the dangers of socialized medicine. Tact, fairness, and pleasing aggressiveness are assets and serve to accomplish much.

In closing, may I stress again the importance of knowing the full meaning of the term "public relations." In this field there is a never-ending amount of work to be done. Let us be ever ready to render that loyalty and support that lies within our power.

Daylight Saving For Better Health

By MRS. ARNOLD H. BARR
Port Washington

IN LINE with the avowed policy of the auxiliary to "interpret the aims of the medical profession to other organizations interested in the promotion of health education" our public relations chairman, Mrs. Bitter, and our program chairman, Mrs. Fuller, are urging a study of the subject of daylight saving. Dr. Ralph P. Sproule, president of the State Medical Society, urged upon Wisconsin doctors at the September convention a campaign to adopt daylight saving time throughout the state. The Medical Society of Milwaukee County has gone on record in support of the plan, and Dr. Sproule has requested that the women throughout the state start considering this matter in their respective counties. There have been and will continue to be many articles and editorials in the Milwaukee Journal on this subject. Watch for these articles. Further information will be given here next month on sources of material for discussion.

According to Dr. Sproule, the subject "is to be presented from an educational point of view, and we hope will be handled entirely on its merits at the time the legislature meets." The following is condensed from an editorial in the October issue of the Milwaukee Medical Times*.

To effect the repeal of the present state law prohibiting daylight saving, many groups, including labor, the farmer and the theater owner, will have to be won over.

Dr. Sproule bases his argument for adoption of daylight saving on its beneficial effect upon public health. By setting all clocks ahead one hour from May 1 to October 1 each year, Wisconsin citizens will be enabled to enjoy more sunshine and thus to store up additional energy to resist disease during the long winters.

Labor, which was chiefly responsible for placing the present law on the statutes, claims that daylight saving deprives the working man of an hour's sleep in the cool of the morning. To this argument Dr. Sproule answers that conditions have changed since 1930, when the law was passed. Under the present forty-hour week, employes start to work half an hour or an hour later and quit work half an hour earlier. Under daylight saving the worker would have four or five hours of daylight to be outdoors, swimming, golfing, picnicking, and playing. The farmer objects to the plan because it means earlier rising to get the milk to town. To this Dr. Sproule replies that farmers in New York, Chicago, Michigan and many other places have accommodated themselves to a more healthful, more modern time set-up without any great hardship.

And we might add that actually the farmers have always run on the daylight saving plan, arising at daybreak and retiring at dark regardless of the hour of the day.

To the theater owner, who objects on the grounds that the public does not care to attend the theater in the daytime, Dr. Sproule points out that air conditioning has changed this situation greatly and that the theaters could well urge patrons to enjoy the cool of the movie house during the heat of the day.

The women of the Auxiliary are asked to discuss the subject from a woman's standpoint also. What, for example can be said to the woman who objects to putting the children to bed while the sun still shines? The women cannot help but find many ways in which daylight saving would greatly benefit the families of our northerly state.

To County Auxiliary Presidents:

Is your chairman of press and publicity sending news of your activities to the state chairman of press and publicity?

We want to know about your programs, your projects, and your social events.

* Courtesy of James O. Kelley, Managing Editor.

AUXILIARY COUNTY MEETINGS

Columbia—Marquette—Adams

The Woman's Auxiliary to the Columbia–Marquette–Adams County Medical Society met with the doctors at dinner at St. Savior's Hospital, Portage, on Tuesday, October 15. The meeting was called to order by the president, Mrs. L. V. McNamara of Montello.

Reports were given by Mrs. J. W. MacGregor of Portage, chairman of membership, and by Mrs. H. E. Gillette of Pardeeville, chairman of archives and history.

The Nominating Committee presented the following slate of officers foı 1940–1941, which was accepted:

President-elect—Mrs. J. P. Harkins, Portage
Secretary—Mrs. J. H. Houghton, Wisconsin Dells
Treasurer—Mrs. H. E. Gillette, Pardeeville

A social time followed adjournment of the business meeting.

Dane

The fall meeting of the Woman's Auxiliary to the Dane County Medical Society was held on October 9 at the Country Club, Cambridge. A one o'clock luncheon was served. The hostesses were Mrs. D. M. Britton, Mrs. C. W. Aageson, Mrs. F. E. Collins, and Mrs. R. L. McIntosh, all of Madison, and Mrs. G. E. Bilstad of Cambridge.

Following the luncheon the meeting was called to order by Mrs. W. H. Krehl of Madison, president. The following officers and chairmen gave annual reports: Mrs. W. A. Werrell, secretary; Mrs. P. A. Duehr, treasurer; Mrs. H. M. Carter, program; Mrs. E. H. Grumke, press and publicity; Mrs. A. W. Bryan, publicity; Mrs. H. K. Tenney, legislation; Mrs. B. I. Brindley, Hygeia; Mrs. S. J. Briggs, loan closet; Mrs. T. W. Tormey, Jr., notification; and Mrs. D. L. Williams, membership.

The Nominating Committee presented the following names: Mrs. C. N. Neupert, Madison, president-elect; Mrs. H. N. Winn, Madison, secretary; Mrs. T. W. Tormey, Jr., Madison, treasurer. These members were approved to serve as officers during 1941. Mrs. Krehl, retiring president, then turned the meeting over to Mrs. H. W. Virgin, Jr., of Madison, incoming president.

Mrs. Virgin appointed the following chairmen for the current term of office: Mrs. D. L. Williams, Madison, membership; Mrs. F. K. Dean, Madison, notification; Mrs. E. H. Grumke, Madison, press and publicity; Mrs. N. A. Hill, Madison, loan closet; and Mrs. F. E. Collins, Hygeia.

Motions were approved to appropriate the sum of $50 to place Hygeia in schools chosen by the committee and also to donate $20 to the loan closet to purchase needed articles.

Nineteen members were present at the meeting. After adjournment of the business meeting bridge was played.

The November meeting of the Dane County Auxiliary was on the eighteenth at the home of Mrs. N. A. Hill, Madison. A one o'clock luncheon was served, hostesses being Mrs. W. J. Ganser, Mrs. C. A. Fosmark, Mrs. D. C. Atwood, Mrs. L. W. Paul, Mrs. H. W. Wirka, and Mrs. B. I. Brindley. There were thirty-eight members present. Following the luncheon, Mr. J. G. Crownhart, secretary of the State Medical Society of Wisconsin, gave an interesting resume of the aims and ambitions of the medical profession regarding the Centennial Convention to be held in Madison in 1941.

The meeting was then called to order by Mrs. C. N. Neupert, and Mrs. John Doolittle gave her report of Hygeia, stating that four towns, Sun Prairie, Belleville, Oregon, and Mount Horeb, had accepted the offer to place Hygeia in their town libraries. Also, the county nurses have assigned forty-eight schools in the county to receive the publication.

Mrs. N. A. Hill gave her report that twenty layettes have been purchased for use by the loan closet and also that $6 had been appropriated to buy rubber sheeting. It was decided to have each member bring a toy to the December meeting, to be distributed to the county nurse.

Fond du Lac

Mrs. S. A. Theisen of Fond du Lac was hostess to eighteen members of the Woman's Auxiliary to the Fond du Lac County Medical Society at a 6:30 dinner, October 31, followed by a business session at which Mrs. D. F. Gosin of Green Bay, state president, was a speaker. Mrs. Gosin, introduced by Mrs. E. H. Pawsat of Fond du Lac, spoke on the aims of the organization.

An appropriation was voted for the Children's Home, and auxiliary members were asked to give as much aid as possible in making bandages for the Red Cross at Grafton Hall. Mrs. Claude Musolf spoke on the Girl Scout troop sponsored by the auxiliary.

Dinner was served at a table decorated with fall flowers and centered with tapers, and the guests, Mrs. Gosin and Mrs. E. S. Schmidt of Green Bay, were presented with corsages. The hostess committee included Mrs. Theisen, chairman, and Mesdames J. P. Connell, J. C. Devine, A. C. Florin, R. R. Dalrymple, and J. W. Doyle, all of Fond du Lac, and Mrs. H. J. Kief of St. Cloud.

Manitowoc

The Woman's Auxiliary to the Manitowoc County Medical Society held its first meeting of the season, Wednesday, October 16, at Dills Tea Room in Manitowoc, Mrs. E. C. Cary of Reedsville, Mrs. J. M. Kelley of Cato, and Mrs. W. A. Rauch of Manitowoc acting as hostesses. Twelve members and one guest, Mrs. Richardson of Two Rivers, were present.

The new president, Mrs. T. A. Teitgen of Manitowoc presided. Mrs. T. H. Rees of Manitowoc and Mrs. Teitgen told about the state convention in Milwaukee. It was voted to do handwork for the Red Cross at the next meeting.

The following officers and committee chairmen took over their new duties for 1940–1941:

Officers

President—Mrs. T. A. Teitgen, Manitowoc
President-elect—Mrs. E. C. Cary, Reedsville
Secretary-Treasurer—Mrs. C. E. Wall, Manitowoc

Committee chairmen

Constitution—Mrs. C. J. Skwor, Mishicot
Hygeia—Mrs. G. M. Hoffman, Manitowoc
Archives—Mrs. J. M. Kelley, Cato
Membership—Mrs. W. E. Donahue, Manitowoc
Program—Mrs. F. E. Turgasen, Manitowoc
Public relations—Mrs. Nathan Schneck, Manitowoc
Social—Mrs. L. W. Gregory, Manitowoc
Press and publicity—Mrs. T. H. Rees, Manitowoc
Telephone—Mrs. R. W. Hammond, Manitowoc
Philanthropic—Mrs. W. A. Rauch, Manitowoc

Milwaukee

The November meeting of the Woman's Auxiliary to the Medical Society of Milwaukee County was held at the Cudworth Post on Friday, November 8. The color motif was red, white, and blue, the tables being decorated with candles and carnations.

Mrs. C. D. Partridge, president, introduced Dr. R. P. Sproule of Milwaukee, president of the State Medical Society, who talked briefly on social problems confronting the medical profession.

The program chairman, Mrs. R. D. Bergen of Milwaukee, presented the speaker, Dr. Howard J. McMurray, professor of political science at the University of Wisconsin Extension Division. His topic, "Axis Bid for Africa," was discussed in a stimulating manner. Dr. McMurray traced the causes of the second World War, the difficulties besetting Great Britain, and what this war will mean to the United States.

A short business meeting followed. Two letters concerning Hygeia were read. Two new members were welcomed into the Auxiliary: Mesdames B. B. Schoenkerman and R. T. Rank, both of Milwaukee. Mrs. W. A. Joseph of Milwaukee urged members to participate in the weekly Red Cross work.

The study group met at eleven o'clock the morning of the regular meeting. Mrs. Ervin Hansher of Milwaukee led the group, and an interesting paper on an eastern medical plan was presented by Mrs. E. J. Behnke. The next meeting will be held December 13.

Rock

Mrs. H. E. Kasten of Beloit was elected president of the Woman's Auxiliary to the Rock County Medical Society at its annual meeting held October 30 following a 6:30 o'clock dinner at the Woman's Club in Janesville. She succeeds Mrs. L. J. Friend, also of Beloit. Mrs. C. R. Gilbertsen, Janesville, was made president-elect. Other officers, all from Beloit, are Mrs. F. E. Brinckerhoff, secretary; Mrs. R. N. Baldwin, treasurer, and Mrs. H. M. Helm, parliamentarian.

Committee appointments were made as follows:

Program, press, and publicity—Mesdames L. J. Friend, R. F. Wilson, V. W. Koch, and C. R. Gilbertsen
Philanthropy—Mesdames W. W. Crockett, C. E. Smith, W. T. Clark, H. C. Danforth, and G. L. Thomas
Public relations—Mesdames O. W. Friske, R. M. Baldwin, E. C. Hartman, and F. W. Van Kirk
Hygeia—Mesdames G. W. John, M. E. Ross, F. E. Brinckerhoff, G. W. Belting, G. S. Metcalf, W. H. McGuire, T. J. Snodgrass, W. A. Munn, and T. L. Vogel
History—Mesdames H. M. Helm and F. C. Binnewies
Social and membership—Mesdames W. H. Hecker, J. C. Springberg, W. T. Clark, T. W. Nuzum, F. M. Frechette
Telephone—Mesdames R. M. Baldwin, E. C. Hartman, and G. W. Bartels

The Rock County Auxiliary has been active in placing copies of Hygeia in homes, schools, and libraries, and in carrying out philanthropic projects. The Janesville group has worked for the benefit of Mercy Hospital and the Beloit members for the Beloit Municipal Hospital. All have cooperated in serving Pinehurst, providing gifts for all patients at Christmas time and offering entertainment from time to time.

Mrs. E. C. Hartman of Janesville was the social chairman for this meeting.

Sauk

The Woman's Auxiliary to the Sauk County Medical Society met at the home of Mrs. A. T. Johnson in Sauk City on Thursday, October 10, for a luncheon, business meeting, and bridge. Assistant hostesses were Mrs. H. A. Bachhuber and Mrs. T. W. Walsh of Sauk City, and Mrs. K. D. Hannan of Prairie du Sac. There were eleven members present. In the absence of the president, the president-elect, Mrs. H. A. Bachhuber, conducted the meeting.

It was decided that before the next meeting each member should make or buy something for a layette. After these layettes are completed they will be available for use, as needed, by the doctors in the various towns of the county. It was decided to do this type of work instead of Red Cross work.

The chairman of the Hygeia Committee asked that some action be taken on whether or not members wanted to subscribe 100 per cent to that

magazine. It was decided that this was a personal issue and should be taken care of by individual members of the organization.

A report was given by the delegate to the state convention, and she was instructed to obtain for auxiliary members more information regarding the Bulletin, publication of the National Auxiliary.

Sheboygan

At a one o'clock luncheon at Benedict's Heidelberg Club in Sheboygan on Wednesday, November 6, members heard a most interesting review of the book "The Nazarene" given by Mrs. Frank Sroub of Sheboygan Falls. The meeting was in charge of Mrs. A. J. Brickbauer of Plymouth, president.

Washington—Ozaukee

The Woman's Auxiliary to the Washington–Ozaukee County Medical Society held its November meeting in West Bend, with a one o'clock luncheon served at the Beacon Restaurant. The business meeting was held at the home of Mrs. A. H. Heidner. Twelve members were present.

Mrs. H. M. Lynch, a member of the Philanthropic Committee, distributed material for dresses and sweaters to be made for the Red Cross.

The next meeting of the auxiliary will be held in Slinger.

Waupaca—Shawano

The Woman's Auxiliary to the Waupaca–Shawano County Medical Society held a meeting at the Hotel Murdock, Shawano, on November 5. Women were present from New London, Shawano, Waupaca, Weyauwega, Marion, Manawa, Clintonville, and Keshena. A one o'clock luncheon preceded the program and business meeting. The Shawano members in charge of the meeting were Mrs. L. W. Peterson, Mrs. R. C. Cantwell, Mrs. A. A. Cantwell, and Mrs. E. L. Schroeder.

New officers elected are: President, Mrs. E. A. Weller, Weyauwega; secretary, Mrs. L. F. Corry, Weyauwega; treasurer, Mrs. F. M. Mulvaney, Marion.

At bridge prizes went to Mrs. E. A. Miller of Clintonville and Mrs. J. W. Monsted of New London.

Winnebago

Yearbooks, containing the names of officers, committees, and the program for the year, were given out on October 28 at the luncheon meeting of the Woman's Auxiliary to the Winnebago County Medical Society, held at the Valley Inn in Neenah. Mrs. W. N. Linn of Oshkosh presided at the business meeting, which was attended by seventeen of the fifty-one members. It was decided to place Hygeia in beauty parlors in Oshkosh, Neenah, and Menasha.

The program outlined indicates the auxiliary will have an entertaining series of monthly gatherings. Officers listed are: Mrs. W. N. Linn, Oshkosh, president; Mrs. G. C. Owen, Oshkosh, president-elect; Mrs. E. B. Williams, Oshkosh, secretary-treasurer; and Mrs. J. W. Lockhart, Oshkosh, parliamentarian.

Committees for the year include:

History and archives—Mrs. J. P. Canavan, Neenah

Convention—Mrs. F. G. Connell, Oshkosh; Mrs. T. D. Smith, Neenah

Hygeia—Mrs. G. H. Williamson, Neenah; Mrs. R. C. Lowe, Neenah; Mrs. L. O. Helmes, Oshkosh; Mrs. H. H. Meusel, Oshkosh; Mrs. G. A. Steele, Oshkosh.

Membership—Mrs. J. W. Lockhart, Oshkosh; Mrs. S. D. Greenwood, Neenah

Press and publicity—Mrs. E. F. Cummings, Oshkosh; Mrs. Burton Clark, Oshkosh; Mrs. J. E. Schein, Oshkosh; Mrs. C. A. Meilicke, Oshkosh; Mrs. I. E. Ozanne, Neenah

Public relations—Mrs. E. B. Pfefferkorn, Oshkosh; Mrs. Adin Sherman, Oshkosh; Mrs. H. W. Kleinschmidt, Oshkosh; Mrs. R. H. Bitter, Oshkosh; Mrs. G. R. Anderson, Neenah

Shut-in—Mrs. J. M. Hogan, Oshkosh; Mrs. B. K. Ozanne, Neenah

Program—Mrs. G. C. Owen, Oshkosh; Mrs. H. A. Romberg, Oshkosh; Mrs. H. J. Lee, Oshkosh; Mrs. H. F. Beglinger, Neenah; Mrs. A. B. Jensen, Menasha; Mrs. T. D. Smith, Neenah

Picnic—Mrs. W. P. Wheeler, Oshkosh; Mrs. A. G. Koehler, Oshkosh; Mrs. S. R. Beatty, Oshkosh; Mrs. W. E. Clark, Oshkosh; Mrs. J. J. Kronzer, Oshkosh; Mrs. G. V. Lynch, Oshkosh; Mrs. J. F. Stein, Oshkosh; Mrs. W. A. Wagner, Oshkosh; Mrs. L. M. Smith, Oshkosh; Mrs. G. E. Forkin, Menasha; Mrs. H. L. Baxter, Neenah; Mrs. P. T. O'Brien, Menasha

A REMINDER TO:

STATE OFFICERS
STATE COMMITTEE CHAIRMEN
COUNTY PRESIDENTS
COUNTY PRESIDENTS-ELECT

Please remember that the mid-year meeting of the Board of Directors will be held early in January. It will offer you a splendid opportunity to meet one another, to review your accomplishments, and to discuss plans for the remainder of the year.

The meeting begins with a luncheon at which you will be guests of the state auxiliary. In the past these have been very enjoyable and inspiring occasions. Therefore, remember to keep your calendar clear so that you may attend the January board meeting! The exact date will be announced later.

Society Proceedings

Ashland—Bayfield—Iron

At a meeting of the Ashland–Bayfield–Iron County Medical Society on November 13 Dr. Hendrie W. Grant, St. Paul ophthalmologist, spoke to the group on "Ocular Manifestations of Head Injuries." At the regular business meeting the following physicians were elected to head the society for the coming year:

President—Dr. C. A. Grand, Ashland
Vice-president—Dr. A. C. Taylor, Washburn
Secretary—Dr. A. H. Lamal, Ashland
Delegate—Dr. J. W. Prentice, Ashland
Alternate delegate—Dr. A. H. Lamal, Ashland

The following physicians were accepted into membership in the society: Drs. W. N. Warvi, Highbridge; Michael J. Bonacci, Hurley; Kenneth Seifert, Washburn; Michael L. Matte, Hurley; and D. J. Martinek, Hurley.

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society held its monthly meeting at the Beaumont Hotel, Green Bay, on November 14, 1940, with forty-seven physicians in attendance. Following the dinner and business meeting, Dr. Emil Hauser, assistant professor of bone and joint surgery at Northwestern University Medical School, spoke to the group on the subject "Diseases of the Foot." The presentation was illustrated with lantern slides.

Calumet

The Calumet County Medical Society met at New Holstein at 8:00 p. m., October 24. The following officers were elected:

President—Dr. J. W. Goggins, Chilton
Secretary—Dr. J. A. Knauf, Stockbridge
Delegate—Dr. F. P. Knauf, Kiel
Alternate delegate—Dr. N. J. Knauf, Chilton

Following the transaction of regular business, the physicians joined in a general round-table discussion.

Chippewa

Twenty physicians attended the dinner meeting of the Chippewa County Medical Society held at the Hotel Northern, Chippewa Falls, November 19. Guest speakers of the evening were Dr. H. E. Marsh, Madison, whose topic was "The Peptic Ulcer Problem," and Dr. Luther Homgren, Madison, who spoke on "Injection Treatment of Hernia." At the regular business meeting the following officers were reelected for 1941:

President—Dr. F. B. Sazama, Chippewa Falls
Secretary-treasurer—Dr. L. W. Picotte, Chippewa Falls
Delegate—Dr. C. B. Hatleberg, Chippewa Falls
Alternate delegate—Dr. A. J. Somers, Chippewa Falls

Crawford

The Crawford County Medical Society held its annual election of officers at a meeting held at the Savory Cafe, Prairie du Chien, on October 29. Officers for the ensuing year are:

President—Dr. G. R. Hammes, Seneca
Vice-president—Dr. E. H. Lechtenberg, Prairie du Chien
Secretary—Dr. O. E. Satter, Prairie du Chien
Treasurer—Dr. R. W. Utendorfer, Prairie du Chien
Delegate—Dr. C. A. Armstrong, Prairie du Chien
Alternate delegate—Dr. G. M. Sargeant, Prairie du Chien
Censor—Dr. E. H. Lechtenberg, Prairie du Chien

Douglas

At a dinner meeting held at the Androy Hotel, Superior, on November 6, 1940, the Douglas County Medical Society elected the following officers for 1941:

President—Dr. Rudolph Christiansen, Superior
Vice-president—Dr. Conrad Giesen, Superior
Secretary-treasurer — Dr. Fred Johnson, Jr., Superior
Delegate—Dr. T. J. O'Leary, Superior
Alternate delegate—Dr. Charles Giesen, Superior

Eau Claire—Dunn—Pepin

Forty physicians were in attendance to hear Dr. H. W. Meyerding, Mayo Clinic, present a paper on the subject of osteomyelitis at a dinner meeting of the Eau Claire–Dunn–Pepin County Medical Society held at the Hotel Eau Claire on October 28.

At its November 25 meeting, the society had as guest speakers Drs. Arthur Hunt and Louis Vaughn of the Mayo Clinic. Dr. Hunt spoke on "Indications for Cesarean Section," and Dr. Vaughn on "Chemotherapy."

Fond du Lac

The Fond du Lac County Medical Society held its regular monthly meeting at the Hotel Retlaw, Fond du Lac, on October 31 at 6:30 p. m. Dr. Ralph P. Sproule, Milwaukee, president of the State Society, spoke on the subject, "The Conscription Law and its Relationship to the Medical Profession."

The following officers were elected for the local society:

President—Dr. O. F. Guenther, Campbellsport
Vice-president—Dr. L. J. Keenan, Fond du Lac
Secretary-treasurer—Dr. S. A. Theisen, Fond du Lac
Delegate—Dr. D. J. Twohig, Fond du Lac
Alternate delegate—Dr. J. C. Devine, Fond du Lac
Censor—Dr. J. E. Twohig, Fond du Lac

Grant

At the October meeting of the Grant County Medical Society the following officers were elected:

President—Dr. H. J. McLaughlin, Bloomington
Vice-president—Dr. H. W. Carey, Lancaster
Secretary-treasurer—Dr. H. L. Doeringsfeld, Platteville
Delegate—Dr. J. D. Glynn, Lancaster
Alternate delegate—Dr. E. H. Spiegelberg, Boscobel

Jefferson

The Jefferson County Medical Society met at the Forest Lawn Sanatorium, Jefferson, at 6:30 p. m., October 24, with twenty-one members in attendance. Dr. L. W. Paul, associate professor of radiology, University of Wisconsin Medical School, spoke to the group on erythema nodosum, and Dr. W. H. Oatway, Jr., assistant professor of medicine, University of Wisconsin Medical School, presented a paper entitled "Newer Methods of Using X-ray in Tuberculosis."

A short business meeting followed the presentation of the scientific papers.

Langlade

The regular monthly meeting of the Langlade County Medical Society was held at the Langlade County Memorial Hospital, Antigo, on October 23. The following officers were elected for the coming year:

President—Dr. R. J. Portman, Antigo
Vice-president—Dr. P. J. Dailey, Elcho
Secretary-treasurer—Dr. W. P. Curran, Antigo
Delegate—Dr. C. E. Zellmer, Antigo
Alternate delegate—Dr. R. J. Portman, Antigo

Outagamie

The Outagamie County Medical Society met at the Masonic Temple, Appleton, on November 14 for a dinner meeting. The scientific program consisted of a symposium of epidural and subdural hematoma in head injuries.

Polk

Members of the Polk County Medical Society were dinner guests of Dr. and Mrs. G. B. Noyes, Centuria, on October 17, at which time the regular meeting of the society was held. Included as a part of the business meeting was a report of the state meeting by the society's delegate, Dr. L. O. Simenstad, Osceola. The following officers were elected for the ensuing year:

President—Dr. W. B. Cornwall, Amery
Vice-president—Dr. D. A. Maas, Webster
Secretary-treasurer—Dr. G. B. Noyes, Centuria
Delegate—Dr. L. O. Simenstad, Osceola
Alternate delegate—Dr. K. F. Johnson, Frederic
Censor—Dr. L. A. Campbell, Jr., Clayton

Following the business meeting, the members participated in a general discussion of certain drugs with special reference to their use in specific diseases.

Portage

The Portage County Medical Society met at the Hotel Whiting, Stevens Point, on November 13 for its regular evening meeting. Dr. W. F. Cowan, Stevens Point, presented a paper on "Ectopic Gestation," discussion of which was opened by Dr. E. E. Kidder, Stevens Point. Dr. George C. Owen, Oshkosh, the guest speaker for the evening, addressed the group on "Postoperative Pulmonary Complications." A lunch and social hour concluded the meeting.

Rock

At the meeting of the Rock County Medical Society on October 29, the following officers were elected for 1941:

President—Dr. G. C. Waufle, Janesville
Vice-president—Dr. J. R. Harvey, Footville
Secretary—Dr. O. V. Overton, Janesville

Trempealeau—Jackson—Buffalo

The Tri-County Medical Society met at the Eagle Hotel at Fountain City at 6:30 p. m., November 14, for a regular meeting and election of officers. As a part of the scientific program a general discussion was held by the physicians present on infantile paralysis cases. Following are the officers elected for the coming year:

President—Dr. Emmett Meili, Cochrane
President-elect—Dr. F. T. Younker, Galesville
Secretary-treasurer—Dr. R. R. Richards, Blair
Delegate—Dr. R. L. MacCornack, Whitehall
Alternate delegate—Dr. Robert Krohn, Black River Falls
Censor (to 1943)—Dr. F. T. Weber, Arcadia
Censor (to 1942)—Dr. I. H. Lavine, Melrose
Censor (to 1941)—Dr. F. C. Skemp, Fountain City

Walworth

A dinner meeting of the Walworth County Medical Society was held at the Walworth County Hospital, Elkhorn, November 6. Dr. W. H. MacDonald, Lake Geneva, talked to the group on the subject of infantile paralysis.

Photograph by Conant, Courtesy Marinette Union–Times.

Pictured above are physicians who attended the meeting of the Menominee (Mich.) and Marinette–Florence County Medical Societies, November 1, in the new Marinette General Hospital.

Seated (left to right) are: Dr. John Walsh, Escanaba, and Dr. M. Fernan–Nunez, Milwaukee (guest speakers); Dr. G. R. Duer, Marinette; Dr. K. G. Pinegar, Marinette; Dr. A. T. Nadeau, Marinette; Dr. H. L. Jorgenson, Marinette; Dr. J. M. Bell, Peshtigo; Dr. H. T. Sethney, Menominee, Mich.; Dr. E. Sawbridge, Stephenson, Mich.; Dr. M. D. Bird, Marinette.

Standing (left to right) are: Mr. J. O. Cederberg (superintendent of the Marinette General Hospital); Dr. G. W. Moll, Escanaba, Mich.; Dr. A. C. Bacchus, Powers, Mich.; Dr. A. N. Tousignant, Oconto; Dr. G. W. Benson, Escanaba, Mich.; Dr. A. F. Slaney, Oconto; Dr. J. C. Scully, Menominee, Mich.; Dr. T. J. Hutton, Powers, Mich.; Dr. F. J. Erdlitz, Peshtigo; Dr. J. W. Towey, Powers, Mich.; Dr. J. T. Kaye, Menominee, Mich.; Dr. R. W. Shaw, Marinette; Dr. S. C. Mason, Menominee, Mich.; Dr. J. V. May, Marinette; Dr. W. S. Jones, Menominee, Mich.; Dr. F. J. Dewane, Menominee, Mich.; Dr. A. R. Peterson, Daggett, Mich.; Dr. H. Barnes, Marinette; Dr. J. W. Boren, Jr., Marinette; Dr. C. E. Koepp, Marinette; Dr. K. C. Kerwell, Stephenson, Mich.; Dr. J. W. Boren, Marinette; Dr. J. D. Zeratsky, Marinette; Dr. H. F. Schroeder, Marinette.

Winnebago

The Winnebago County Medical Society held its regular meeting at the Menasha Hotel, Menasha, November 7, at 6:30 p. m. The speaker of the evening was Dr. Joseph Lettenberger, associate clinical professor of medicine, Marquette University School of Medicine, whose topic was "Fundamentals in Daily Practice." During the regular business meeting the following officers were elected:

President—Dr. F. G. Jensen, Menasha
Vice-president—Dr. M. C. Haines, Oshkosh
Secretary—Dr. E. F. Cummings, Oshkosh
Delegate—Dr. A. G. Koehler, Oshkosh
Alternate delegate—Dr. J. P. Canavan, Neenah

First Councilor District

The annual meeting of the First Councilor District was held at Rogers Memorial Sanitarium, Oconomowoc, on October 16. The scientific meeting was called to order at 3:30 p. m. Dr. M. J. Fox of Milwaukee presented a paper on infantile paralysis, which was followed by a discourse on the orthopedic treatment of infantile paralysis by Dr. H. C. Schumm, Milwaukee. A discussion followed.

Election of officers was held as follows:

Dr. L. H. Nowack, Watertown, president
Dr. A. C. Hahn, Watertown, vice-president
Dr. H. G. Mallow, Watertown, secretary

A buffet supper followed after which a comic lecture was presented by Mr. Oathouse of Waukesha.

Ninth Councilor District

Physicians of the ninth councilor district met at the Hotel Wausau, Wausau, for a 6:00 o'clock dinner meeting on November 7. Dr. H. C. Schumm, Milwaukee, presented movies illustrating methods of first aid and transportation of the injured. Dr. C. A. Dawson, River Falls, talked to the group on "Problems of Organized Medicine in Wisconsin."

Tenth Councilor District

The annual get-together of physicians of the tenth councilor district was held at Eau Claire on October 10. Dr. Carl S. Harper, Madison, the guest speaker, chose as his subject, "Gynecological Office Practice."

Milwaukee Oto-Ophthalmic Society

Members of the Milwaukee Oto-Ophthalmic Society met for a dinner meeting at the University Club, Milwaukee, November 12. Dr. A. D. Ruedemann, chief of the department of ophthalmology, Cleveland Clinic, Cleveland, was the speaker of the evening. His subject for discussion was "Headache and Head Pain of Ocular Origin." Drs. F. H. Haessler and T. L. Tolan, Milwaukee, lead the discussion of the paper.

Milwaukee Neuro-Psychiatric Society

On November 28 the Milwaukee Neuro-Psychiatric Society met at the University Club. The guest speaker was Dr. Roy Grinker of Chicago. He gave an address on "Some Modern Problems in Neuropsychiatry."

News Items and Personals

About 600 dermatologists from the United States and Canada met in Chicago on December 8 for the third annual meeting of the American Academy of Dermatology and Syphilology. In addition to lectures, symposia and round-table discussions, clinical presentations were given at the University of Illinois Medical School in Chicago. Wisconsin physicians appearing on the program included: *Dr. Elmer L. Sevringhaus*, professor of medicine, University of Wisconsin Medical School, who addressed the group on "Endocrines and their Relation to Dermatology," and *Dr. Otto H. Foerster*, Milwaukee, professor of dermatology, University of Wisconsin Medical School, who led a symposium on pharmaceutical therapeutics.

Dr. Harry R. Foerster, Milwaukee, assistant professor of dermatology, University of Wisconsin Medical School, and assistant clinical professor of dermatology at Marquette University School of Medicine, is president of the American Academy of Dermatology and Syphilology.

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Physicians from Madison and neighboring communities and the University of Illinois Medical School attended a postgraduate clinic at the Jackson Clinic on November 2.

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Dr. R. S. Baldwin, Marshfield, a captain in the medical reserve corps, has been ordered to Fort Sheridan, Illinois, for service with the United States army. Dr. Elizabeth Reddeman, wife of Dr. Baldwin, will take over his practice during his absence.

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Under the curatorship of *Dr. Eben J. Carey*, dean, Marquette University Medical School, the first public museum on the medical and health sciences opened at the Museum of Science and Industry in Jackson Park, Chicago, on October 26. It was formally dedicated on October 24 at a preview attended by Dr. Carey.

The museum has been in preparation since the close of the Chicago World's Fair; its nucleus came from the medical exhibits of the fair, which were gathered under the leadership of Dr. Carey.

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Dr. E. R. Krumbiegel, city health commissioner, Milwaukee, spoke before the Wisconsin chapter of the American Foundrymen's Association on November 15, at a meeting held at the Hotel Schroeder. His subject was "Public Health in Milwaukee."

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Dr. Peter Theobald, Oconomowoc, addressed the Oconomowoc Rotary Club at its meeting on November 4. He brought to the members and their guests the story of infantile paralysis,—its early history, its effects, and scientific advances and discoveries to counteract the disease. *Dr. T. H. Nammacher*, city health officer, gave a report on local precautions taken against certain diseases.

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Three thousand persons gathered on November 3 to witness the laying of the cornerstone of the new St. Alphonsus Hospital at Port Washington. Those participating in the impressive ceremonies were *Dr. C. H. Kalb*, Grafton, secretary of the Washington–Ozaukee County Medical Society; U. S. Senator Robert M. LaFollette; State Senator H. W. Bolens; Milwaukee's Mayor Carl Zeidler; Assemblyman N. J. Bichler, Belgium; and others.

The hospital is being built by the Sisters of the Sorrowful Mother who have their headquarters in Milwaukee. It will have a capacity of sixty-five beds and is to cost in the neighborhood of $225,000. The city of Port Washington donated the land for the building. Other hospitals in the state maintained by the Sisters of the Sorrowful Mother are at Marshfield, Oshkosh and Rhinelander.

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Dr. W. E. Bannen, La Crosse, spoke at a community meeting in La Crosse on November 12, at which time he outlined the history of immunization and explained more fully the immunization program to be conducted for a local high school district.

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Physicians from many nearby counties attended the mid-Wisconsin conference on tuberculosis held at Wisconsin Rapids on October 29. Wisconsin physicians appearing on the program were *Dr. T. L. Harrington*, Stevens Point; *Dr. A. A. Pleyte*, Milwaukee; *Dr. H. H. Christensen*, Wausau; *Dr. H. H. Christofferson*, Colby; *Dr. F. X. Pomainville*, Wisconsin Rapids; *Dr. E. M. Macaulay*, Wausau; and Dr. J. A. Carswell, Milwaukee.

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A grant from the Therapeutic Research Committee of the American Medical Association to *Dr. Harry Beckman*, Marquette University School of Medicine, has been renewed for another year to partially support his studies in the prophylaxis of avian malaria.

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The University of Wisconsin board of regents voted recently to purchase the valuable medical–historical library of the late Dr. William Snow Miller, former professor of anatomy in the University of Wisconsin Medical School.

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Dr. Gordon Petersen, Neenah, spoke before members and guests of the Washington Parent-Teachers Association on October 28. His topic was cancer.

Drs. Walter Boothby and W. R. Lovelace II, Mayo Clinic, and Capt. Harry Armstrong, army medical corps, were awarded the annual Collier trophy for their medical research work on what happens to a flyer's brain, nerves, blood, and reflexes when he ascends into the stratosphere. It may be remembered that Drs. Boothby and Lovelace presented an interesting exhibit and lecture at the annual meeting of the State Medical Society on the physiologic aspects of aviation. An article by them on the subject is scheduled for publication in The Journal in 1941.

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Muirdale Sanatorium, Wauwatosa, observed its twenty-fifth anniversary on November 24. Among those taking part in the birthday program were *Dr. A. L. Banyai, Dr. Oscar Lotz,* and *Dr. L. L. Allen*—a member of the staff since 1916.

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Dr. Albert Leigh, Kaukauna, spoke before a local Parent-Teachers Association on November 19. His subject was "Children's Health in Connection with School Work."

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About 175 people attended the annual banquet meeting of Twin Lakes Council, Boy Scouts of America, held at Oshkosh on November 14, at which *Dr. A. M. Christofferson, Waupaca,* was presented with the Silver Beaver Award after having been cited for valuable leadership and services to the Boy Scouts of America in his district.

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Dr. C. P. Reslock, Waupun, spoke on socialized medicine at a meeting of the Fond du Lac Kiwanis Club, October 24.

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Dr. Joseph F. Smith, Wausau, has been re-elected to the presidency of the Marathon county unit of the Wisconsin Association for the Disabled.

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The history of immunization and treatment of the common cold were discussed on October 22 by *Dr. Irving Auld,* Clintonville, at a meeting of the department heads of the Four Wheel Drive Auto Company, truck manufacturers.

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Dr. M. P. Andrews, Manitowoc, spoke at a dinner meeting of the Lions Club at the Hotel Manitowoc on November 5. He discussed dust hazards.

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Dr. C. J. Smiles, Ashland, has been elected a trustee of the Pureair Sanatorium for a three-year period. He succeeds the late Dr. M. S. Hosmer, Ashland.

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Dr. Matthew N. Federspiel, associate clinical professor of surgery, Marquette University School of Medicine, warned against unreliable dental diagnoses in a talk before the ninth councilor meeting of the Wisconsin State Dental Society held in Madison on November 14.

At a meeting of the Marquette University School of Medicine Alumni Association on November 8 the following physicians were named officers of the board of directors:

President—*Dr. Erwin C. Cary,* Reedsville
Vice-president—*Dr. Joseph Gramling, Jr.,* Milwaukee
Treasurer—*Dr. Dexter H. Witte,* Milwaukee

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Dr. A. M. Schwittay, Madison, spoke on "Physiology and Hygiene of the Reproductive System" at a meeting held in Esther Vilas hall of the Madison YWCA on November 18. The talk was sponsored by the health education committee of the YWCA and was open to the public.

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The 1940 meeting of the Clinical Orthopaedic Society was held in Milwaukee, October 18, and in Madison, October 19, with *Dr. H. C. Schumm,* Milwaukee, presiding as chairman at the Pfister Hotel, Milwaukee, and *Dr. R. E. Burns,* Madison, as chairman at the Loraine Hotel, Madison. Among those who appeared on the program were the following Wisconsin physicians: *A. C. Schmidt, C. C. Schneider, W. P. Blount, S. A. Morton, E. J. Carey, L. D. Smith, J. O. Dieterle, R. P. Montgomery, D. J. Ansfield,* all of Milwaukee; *R. M. Carter,* Green Bay; *W. S. Middleton, H. L. Greene, H. W. Virgin, E. S. Gordon, H. W. Wirka,* E. R. Nelson, J. E. Miller, J. W. Nellen, and S. C. Rogers, all of Madison.

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Dr. R. G. Strong, Manitowoc city physician, is taking postgraduate work at the University of Nebraska Medical School. *Dr. C. E. Wall* is taking care of Dr. Strong's practice in his absence.

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Dr. Otto S. Blum, member of the State Medical Society who formerly practiced at Albany, is now associated with Drs. H. W. Rathe and O. C. Hardwig of Waverly, Iowa. He is specializing in ophthalmology and otolaryngology.

—△—

Emergency problems of diagnosis and treatment which confront the intern were discussed at the Wisconsin General Hospital staff meeting, December 3, in Madison. Over twenty physicians appeared on the program.

BIRTHS

A daughter, Jennifer Margaret, to Dr. and Mrs. L. C. Pomainville, Wisconsin Rapids, on November 9.

A son to Dr. and Mrs. Elwood W. Mason, Milwaukee, on November 25.

MARRIAGES

Dr. A. A. Holbrook, Milwaukee, and Miss May Baldwin, Montgomery, Alabama, on November 16.

Dr. H. J. Jeronimus, Jr., Osceola, and Miss Betty Almars, Minneapolis, in November.

DEATHS

Dr. A. L. Beier, for twenty-one years superintendent of the Northern Wisconsin Colony and Training School, Chippewa Falls, died on November 13 in a Madison hospital after an illness of several months. He was 56 years of age.

Dr. Beier was born in Antigo, Wisconsin. In 1907 he was graduated from the Wisconsin College of Physicians and Surgeons, Milwaukee, and thereafter practiced general medicine in Marinette and Appleton. In 1908 he became assistant superintendent of the Wisconsin Home for the Feeble-minded (now the Northern Wisconsin Colony and Training School), a position he held until he was appointed superintendent of the institution in 1919.

The doctor was a member of the Chippewa County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the American Psychiatric Association, the American Association for the Study of the Feeble-Minded, and the Wisconsin Historical Society. He was the author of many valuable articles on psychiatric and related topics. Dr. Beier, in his work at the Northern Colony and Training School, stressed outdoor pageants and managed elaborate productions annually.

He is survived by his widow and three children.

Commander E. C. Ebert, M. D., medical inspector on the U. S. S. Relief, died suddenly of a heart attack, November 14, in Long Beach, California. He was 51 years of age.

The doctor, a native of Caroline, Wisconsin, was graduated from Marquette University School of Medicine in 1916. He is survived by his mother, two brothers and two sisters. One of his brothers, Dr. R. O. Ebert, lives in Oshkosh.

Dr. Joseph I. Esch, La Farge, died at his home on October 22, the victim of a heart attack.

Dr. Esch was born in Pennsylvania, May 21, 1869, and received his medical degree in 1898 from the Eclectic Medical College, Cincinnati, Ohio. He had been in practice at La Farge for the last forty years. He told many interesting tales of his "horse and buggy days."

The doctor is survived by his widow and one son.

Dr. Albert G. Jenner died at his home in Milwaukee on November 10, at the age of 64 years.

Dr. Jenner, a native of Milwaukee, received his degree of doctor of medicine at the University of Pennsylvania School of Medicine, Philadelphia, in 1897, and took postgraduate work at medical centers in Europe. The doctor had practiced continuously in Milwaukee since 1904, with the exception of two years when he served overseas as a captain in the army. Dr. Jenner is survived by his widow.

Dr. A. S. Maxson, for many years a practicing physician at Milton Junction, died at his home there on November 7. He was 83 years of age.

Dr. Maxson was born on a farm near Milton, May 11, 1857. He was graduated from Northwestern University Medical School in 1882. He began the practice of medicine at Milton Junction in 1885, but because of impaired health he retired in 1915. The doctor was very active in the community and civic life of Milton Junction, where he was manager of the Milton Junction Telephone Company, a trustee of Milton college and president of the Bank of Milton.

Dr. Maxson is survived by his widow and two daughters.

Dr. L. H. Oliver, Waupun, was the victim of a heart attack at his home on October 30.

Dr. Oliver was born in Long Prairie, Minnesota, October 21, 1886, and later attended Marquette University School of Medicine, from which he was graduated in 1916.

The doctor had been engaged in the practice of medicine at Waupun for the last ten years.

Surviving him are his widow and two daughters.

Dr. H. C. Waddle, Janesville, died in a Madison hospital, November 9.

The doctor was born June 24, 1867, near Renault, Illinois. After his graduation from the University of Illinois College of Medicine in 1903, he began the practice of his profession in Elgin, Illinois. Later he moved to South Wayne, Wisconsin, where he remained in practice until 1938, when he moved to Janesville. He is survived by two daughters.

CORRESPONDENCE

"UNUSUALLY LARGE MALE CHILD . . ."

Walworth, Wisconsin, November 20, 1940.

Mr. J. George Crownhart,
State Medical Society,
Madison, Wisconsin.

Dear Mr. Crownhart: An unusually large male child was delivered by me, at the Walworth County Hospital on the morning of November 12, 1940. Because of its exceptionally large size, I believe it may be of some interest to the State Medical Society as a matter of record.

Weight at birth was fifteen pounds and thirteen ounces. The infant's body measurements are fairly well proportioned to its weight and are as follows:

Length	24	inches
Head, circumference	17	inches
Chest	18	inches
Waist, at umbilicus	18	inches
Shoulders	21	inches
Circumference at trochanters	20	inches
Neck	11½	inches
Thighs	10	inches

The above weight and measurements are recorded at the Walworth County Hospital, Elkhorn, Wisconsin.

Very truly yours,
W. W. Coon, M. D.

A Letter to the Medical Editor

ALCOHOLISM

October 28, 1940.

Karl H. Doege, M. D.,
Editor, State Medical Journal,
Marshfield, Wisconsin.

Re: Alcoholism

Dear Doctor Doege: "The United States has facilities for the control of disease and the conservation of health and vigor superior to those of any other nation. But in respect to one major disease, *Alcoholism*, there has been tragic neglect."

The above quotation is from a recent brochure published by the Research Council on Problems of Alcohol, an associated society of the American Association for the Advancement of Science, 60 East 42nd Street, New York City. This Research Council asks this pertinent question: "Why Is Alcoholism So Great a Menace?" And it answers its own question in this wise: "Alcoholism has become a serious menace to the health and vigor of the nation because we have regarded it as a *moral offense* instead of a *disease*. We have been afraid to look the facts in the face."

Let us make no mistake about this matter, Doctor Doege! Unless organized medicine asserts a leadership in this tragic situation, we may expect leading questions from the lay press as to just why the medical profession is so ardent in its fight against cancer, tuberculosis, syphilis, etc., and so wary of a fight against alcoholism.

The late Dr. William Mayo, speaking to the members of the Mayo Clinic Staff, January 10, 1934, at their weekly staff meeting, said (among other relevant matters): "The majority of pharmacologists agree that alcohol is not a stimulant, but a narcotic; that it is a drug with little use in the practice of medicine. In dealing with addiction to liquor, the difficulty is that we cannot tell in advance who may become victims. We have no test, except the test of time, which ruins a man; nor, have we any remedy to prevent his becoming an addict. Consequently, three men in ten take a chance. As doctors, we must begin to think of promoting the cause of temperance."

If you have kept a file of the Mayo Clinic Weekly Staff Proceedings, you will find my quotation correct to the word. This quotation, combined with the rest of Doctor Mayo's address the same evening, composes the most effective temperance address it has been my privilege to hear or read. What would our Editorial Board say with regard to printing this quotation in an early number of our State Medical Journal? Editorial comment need not be made, although it would be, it seems to me, very pertinent.

With all good wishes, I am

Very sincerely,

SPENCER D. BEEBE, M. D.,
Sparta, Wisconsin.

SOCIETY RECORDS

New Members

H. D. Grota, Sturgeon Bay

C. T. Michna, Denmark.

C. C. Davin, 625 Fifty-seventh Street, Kenosha.

E. J. Zeiss, 103 West College Avenue, Appleton.

J. J. Werner, 3603 West North Avenue, Milwaukee.

G. D. Straus, 324 East Wisconsin Avenue, Milwaukee.

L. J. Drozniakiewicz, 2365 South Thirteenth Street, Milwaukee.

H. W. Pohle, 425 East Wisconsin Avenue, Milwaukee.

B. J. Bertram, Algoma.

L. L. Fifrick, 1324 West Wisconsin Avenue, Milwaukee.

S. F. Schwartz, 735 North Water Street, Milwaukee.

J. F. Imp, 4225 North Forty-seventh Street, Milwaukee.

V. C. Turner, 425 East Wisconsin Avenue, Milwaukee.

S. H. Kash, 3624 East Layton Avenue, Cudahy.

J. W. Fulton, 7037 West Greenfield Avenue, West Allis.

R. R. Weller, 536 West Wisconsin Avenue, Milwaukee.

H. L. Correll, 324 East Wisconsin Avenue, Milwaukee.

W. H. Frackelton, 324 East Wisconsin Avenue, Milwaukee.

I. I. Cash, 735 North Water Street, Milwaukee.

A. J. Dupont, 217 North Washington Street, Green Bay.

Changes in Address

L. W. Nowack, Watertown, to Medical Department Detachment, 127th Infantry, 32nd Division, Camp Beauregard, Alexandria, Louisiana.

E. P. Huth, Belgium, to 3514 Spring Gardens Street, Apartment 31–A, Philadelphia, Pennsylvania.

C. B. Strauch, Milwaukee, to Hazel Green.

E. B. Keck, Madison, to Post Hospital, Marine Barracks, Quantico, Virginia.

W. J. Mauermann, Oregon, to Beloit.

E. R. Krumbiegel, Beaver Dam, to Health Department, Milwaukee.

J. J. Smullen, Arpin, to Wisconsin Rapids.

A. J. Wagner, Brillion, to First Lieutenant, M. O., Induction School, Fort Sheridan, Illinois.

V. A. Toland, Fond du Lac, to 4961 Laclede, St. Louis, Missouri.

O. S. Blum, Welsh, West Virginia, to Waverly, Iowa.

T. E. Wyatt, Marshfield, to First Lieutenant, M. C., Station Hospital, Camp Beauregard, Louisiana.

D. W. Calvy, Elkhart Lake, to 11 North Main Street, Fond du Lac.

Coming Events

Clinics of the University of Wisconsin Medical School.—Physicians are invited to attend clinics held on Saturdays from 11 a. m. to 12:30 p. m., in the Service Memorial Institute, Madison. Scheduled for December 14 is a clinic on the surgical treatment of diseases of the chest, to be presented by Dr. J. W. Gale and his associates.

Physicians are also welcome to attend ward rounds, operating clinics, conferences and seminars, a detailed schedule of which may be obtained from the Dean of the Medical School, Dr. W. S. Middleton.

Staff meetings are held bi-weekly during the academic year.

Clinics for January are listed below:

January 4:
Neuropsychiatry: Early Manifestations of Neurosyphilis—Dr. W. F. Lorenz and associates.

January 11:
Neuropsychiatry: Neurological Disorders Seen by the General Practitioner—Dr. H. H. Reese and associates

January 18:
Neuropsychiatry: Early Symptoms of Common Forms of Mental Disease—Dr. Lorenz and associates

January 25:
Urology: Problems of Chronic Infections of the Prostate—Dr. I. R. Sisk and associates

Clinics of Marquette School of Medicine.—Physicians are cordially invited to attend the weekly clinics at the Milwaukee County Hospital, held every Friday from 10:30 a. m. to 12 noon. Subjects for discussion in December are given below:

December 13:
Hypertension; the Management of Early Cases—Dr. George K. Fenn, associate professor of medicine, Northwestern University Medical School.
Treatment of Burns.

December 20:
Edema and Its Management.
Blastomycosis and Its Surgical Aspects.

Clinics of Milwaukee Children's Hospital.—Clinics scheduled for presentation in the amphitheater of the Milwaukee Children's Hospital in December and January, 1941, are listed below:

DECEMBER

Pediatric Clinic, Friday, December 13:
Special Clinic. 1:00 to 3:00 p. m.

Surgical Clinic, Monday, December 15:
Presentation of cases. Discussion of Physiologic Considerations in Pediatric Surgery.

Fracture Service Clinic, Tuesday, December 17:
Fractures at the wrist in Children. Discussion by A. A. Schaefer, M. D., Milwaukee.

Pediatric Clinic, Friday, December 20:
Diabetes. Discussion by G. F. Kelly, M. D., Milwaukee.

Clinics of Milwaukee Children's Hospital—continued

JANUARY, 1941

Surgical Clinic, Monday, January 6:
Presentation of cases. Discussion of Burns.

Orthopedic Clinic, Tuesday, January 7:
Tuberculosis of the Bone in Children. Discussion by H. C. Schumm, M. D., Milwaukee.

Pediatric Clinic, Friday, January 10:
Special Clinic. 1:00 to 3:00 p. m.

Surgical Clinic, Monday, January 13:
Presentation of cases. Discussion of Intracranial Injuries.

Fracture Service Clinic, Tuesday, January 14:
Fractures of the Spine and Pelvis in Children. Discussion by R. P. Montgomery, M. D., Milwaukee.

Pediatric Clinic, Friday, January 17:
Subject open. Discussion by Horace K. Tenney, Jr., M. D., Madison.

Surgical Clinic, Monday, January 20:
Presentation of cases. Discussion of Osteomyelitis.

Orthopedic Clinic, Tuesday, January 21:
Scoliosis in Childhood. Discussion by Emil Hauser, M. D., Chicago.

Pediatric Clinic, Friday, January 24:
Cerebral Degeneration and Scleroses. Discussion by E. D. Schwade, M. D., Milwaukee.

Third Annual Congress on Industrial Health.—Arrangements have been completed for the third annual Congress on Industrial Health sponsored by the American Medical Association, to be held January 13 and 14, 1941, at the Palmer House in Chicago. The meetings are open to all physicians and others interested in the industrial health movement. There is no registration fee.

OPENING SESSION, MONDAY, 9:45 A. M.

Report of the Council on Industrial Health:
Stanley J. Seeger, M. D., Chairman, Milwaukee.

The Physician in Industry and National Defense:
Irvin Abell, M. D., Chairman, Health and Medical Committee in the Council of National Defense, Louisville, Ky.

Current Needs in Industrial Hygiene Research:
Philip Drinker, Professor of Industrial Hygiene, Harvard University, Boston.

The Special Nature of Industrial Practice:
C. O. Sappington, M. D., Chicago.

Disability Evaluation in Silicosis.
J. L. Blaisdell, M. D., Porcupine Clinic for Silicosis Research, St. Mary's Hospital, Timmins, Ontario.
Red Lacquer Room.

MONDAY, 2 P. M.

HAND INJURIES

Anatomic Diagnosis of Injuries of the Hand:
James M. Winfield, M. D., Associate Professor of Surgery, Wayne University College of Medicine, Detroit.

Treatment of Superficial Hand Injuries and Burns:
Harvey S. Allen, M. D., Chicago.

Division of the Nerves and Tendons of the Hand:
Michael Mason, M. D., Chicago.

Importance of Purposeful Splinting Following Injuries of the Hand:
Henry C. Marble, M. D., Boston.

Prevention and Treatment of Hand Infections:
Sumner L. Koch, M. D., Chicago.
Red Lacquer Room.

Monday, 2:30 P. M.

AVAILABILITY OF TRAINED INDUSTRIAL HEALTH PERSONNEL

The Trained Industrial Nurse:
Ruth Houlton, R. N., Secretary, Industrial Nursing Section, National Organization for Public Health Nursing, New York.

The Industrial Hygiene Engineer:
(Speaker to be announced.)

The Safety Engineer:
W. H. Cameron, Managing Director, National Safety Council, Inc., Chicago.

The Medical Industrial Hygienist:
Paul A. Neal, M. D., Chief of the Division of Industrial Hygiene, National Institute of Health U. S. Public Health Service, Bethesda, Md.

The Physician in Industry:
Robert T. Legge, M. D., University of California, Berkeley, Calif.
Room 8.

Monday, 6:30 P. M.

An informal dinner and round table discussion intended primarily for state and county medical society committees on industrial health will be held. (Mr. J. G. Crownhart, secretary of the State Medical Society of Wisconsin, will participate in the round-table discussions.) The subject matter for discussion will include problems of organization and plans for future activity.

Tuesday, 9:30 A. M.

Employment of the Physically Handicapped:
D. L. Lynch, M. D., President, American Association of Industrial Physicians and Surgeons, Boston.

Aging as a Problem of Industrial Health:
Edward J. Stieglitz, M. D., Research Associate in Gerontology, National Institute of Health, U. S. Public Health Service, Bethesda, Md.

ACUTE RESPIRATORY DISEASE IN INDUSTRY

Incidence and Costs of Acute Respiratory Disease in Industry:
Anthony J. Lanza, M. D., Assistant Medical Director, Metropolitan Life Insurance Company, New York.

Respiratory Disease and Air Conditioning:
Carey P. McCord, M. D., Chairman, Committee on Air Conditioning of the American Medical Association, Detroit.

The Role of the Physician in Industry in the Control of Acute Respiratory Disease:
George M. Piersol, M. D., Philadelphia.
Red Lacquer Room.

Tuesday, 2 P. M.

INDUSTRIAL OPHTHALMOLOGY

Economic Importance of Visual Disability in Industry:
Leonard Greenburg, M. D., Chairman, Industrial Advisory Committee of the National Society for the Prevention of Blindness, New York.

Essentials of First Aid and Later Management of Industrial Eye Injuries:
Sydney Walker Jr., M. D., Chicago.

Detection and Control of Defective Vision in Industry:
Arthur M. Culler, M. D., Dayton, Ohio.

Protective Equipment for Eyes in Industry:
Thomas D. Allen, M. D., Associate Clinical Professor of Ophthalmology at Rush Medical College, Chicago.
Henry F. Carman, M. D., San Francisco.
Red Lacquer Room.

Wednesday, January 15

On the day following the congress, the Chicago Medical Society will conduct clinics illustrating practical problems in industrial medicine, industrial hygiene and traumatic surgery.

On the same day the Chicago Medical Society will hold a dinner and evening meeting on the relationship of the private practitioner to the industrial health movement. The program will be:

Industrial Health—A Medical Opportunity:
Stanley J. Seeger, M. D., Chairman, Council on Industrial Health, American Medical Association, Milwaukee.

Medical Service for the Small Plant:
Anthony J. Lanza, M. D., New York.

The Control of Syphilis in Industry:
Harold A. Vonachen, M. D., Peoria, Ill.

Further details regarding clinics and other demonstrations will be provided registrants at the congress, all of whom are invited to participate.

COMING EXAMINATIONS

Board of Medical Examiners: Hotel Loraine, Madison, Jan. 14–16. (Basic science certificate required.) Application should be made to Dr. H. W. Shutter, Sec., Room 404, 425 E. Wisconsin Ave., Milwaukee, and must be on file not later than Jan. 3 or 4 for favorable consideration.

American Board of Anesthesiology: Written. Various centers, Feb. 20. Final date for filing application is December 21. Oral. Part II. Cleveland, May 31–June 1. Final date for filing application is April 1. Sec., Dr. Paul M. Wood, 745 Fifth Ave., New York.

American Board of Internal Medicine: Written. Parts 1-A and 1-B, Feb. 17. Final date for filing application is Jan. 1. Sec., Dr. William S. Middleton, 1300 University Ave., Madison, Wis.

American Board of Obstetrics and Gynecology: Part I, Group B, in various cities in U. S. and Canada, Jan. 4, 1941, at 2 p. m. (Formal notice will be sent each candidate several weeks in advance of examination date.) Part II, Groups A and B, Cleveland, May 28–June 1. Final date for filing application is March 15. Sec., Dr. Paul Titus, 1015 Highland Bldg., Pittsburgh.

American Board of Pathology: Oral and written. Cleveland, June 1–2. Final date for filing application is May 1. Sec., Dr. F. W. Hartman, Henry Ford Hospital, Detroit.

American Board of Pediatrics: New York, March 30–31, following the Region I meeting of the American Academy of Pediatrics. Chicago, May 18, following the Region III meeting of the American Academy of Pediatrics. Sec., Dr. C. A. Aldrich, 723 Elm St., Winnetka, Ill.

Medical Examiners Under Selective Service

(As of November 20, 1940; other appointments to be made.)

Medical Director

Dr. O. R. Lillie, 208 E. Wisconsin Ave., Milwaukee

Assistant Medical Director

Major John A. Grab, Selective Service, State Capitol, Madison

Local Board Examiners

Adams—G. F. Treadwell, Friendship
Ashland—Wm. J. Tucker, Ashland
Barron—C. C. Post, Barron
Bayfield—A. C. Taylor, Washburn
Brown—E. S. Knox, Green Bay; F. J. Gosin, Green Bay; J. P. Lenfestey, De Pere
Buffalo—B. F. Johnson, Mondovi
Burnett—Clarence L. Treadwell, Siren
Calumet—N. J. Knauf, Chilton
Chippewa—J. A. Kelly, Chippewa Falls; Herbert M. Trankle, Bloomer
Clark—H. H. Christofferson, Colby
Columbia—C. W. Henney, Portage
Crawford—C. A. Armstrong, Prairie du Chien
Dane—Michael Coluccy, Madison; C. O. Vingom, Madison; Harry A. Keenan, Stoughton; David Atwood, Madison.
Dodge—E. P. Webb, Beaver Dam; P. F. Langenfeld, Theresa
Door—F. C. Huff, Sturgeon Bay
Douglas—H. J. Orchard, Superior; J. H. Weisberg, Superior
Dunn—I. V. Grannis, Menomonie
Eau Claire—E. L. Mason, Eau Claire; Herman Prill, Augusta
Fond du Lac—D. J. Twohig, Fond du Lac; O. F. Guenther, Campbellsport
Florence—Francis DeSalvo, Niagara
Forest—Hector Marsh, Crandon
Grant—R. C. Godfrey, Lancaster; C. M. Schuldt, Platteville
Green—L. A. Moore, Monroe
Green Lake—A. J. Wiesender, Berlin
Iowa—H. D. Ludden, Mineral Point
Iron—M. J. Bonacci, Hurley
Jackson—Irwin K. Krohn, Black River Falls
Jefferson—G. E. Eck, Lakemills; H. O. Caswell, Fort Atkinson
Juneau—A. R. Kaufman, Mauston
Kenosha—C. H. Gephardt, Kenosha; F. D. Curtiss, Kenosha; J. H. Cleary, Kenosha
Kewaunee—D. B. Dana, Kewaunee
La Crosse—George Skemp, La Crosse; N. P. Anderson, La Crosse
Skemp, La Crosse
LaFayette—H. F. Hoesley, Shullsburg
Langlade—C. E. Zellmer, Antigo
Lincoln—K. A. Morris, Merrill
Manitowoc—Arthur Teitgen, Manitowoc; L. J. Moriarty, Two Rivers
Marathon—V. E. Eastman, Wausau; J. A. Jackson, Mosinee; P. Z. Reist, Wausau
Marinette—J. W. Boren, Marinette
Marquette—H. Fredrick, Sr., Westfield
Monroe—C. S. Phalen, Sparta
Oconto—W. C. Watkins, Oconto
Oneida—C. A. Richards, Rhinelander
Outagamie—Earle F. McGrath, Appleton; G. J. Flanagan, Kaukauna; W. H. Towne, Hortonville
Ozaukee—O. J. Hurth, Cedarburg
Pepin—G. E. Bryant, Pepin
Pierce—C. A. Dawson, River Falls
Polk—L. O. Simenstad, Osceola
Portage—M. G. Rice, Stevens Point
Price—H. B. Norviel, Phillips
Racine—R. D. Jamieson, Racine; F. W. Pope, Racine; G. L. Ross, Racine; J. F. Bennett, Burlington
Richland—Gideon H. Benson, Richland Center
Rock—S. A. Freitag, Janesville; Willard Sumner, Edgerton; Geo. W. John, Beloit
Rusk—Woodruff Smith, Ladysmith
St. Croix—J. W. Livingstone, Hudson
Sauk—A. C. Edwards, Baraboo
Sawyer—E. H. Dufour, Hayward
Shawano—Carl Stubenvoll, Shawano
Sheboygan—F. A. Nause, Jr., Sheboygan; T. J. Gunther, Sheboygan; A. C. Radloff, Plymouth
Taylor—L. E. Nystrum, Medford
Trempealeau—R. N. Leasum, Osseo
Vernon—R. S. Hirsch, Viroqua
Vilas—O. R. McMurry, Eagle River
Walworth—D. H. Jeffers, Lake Geneva
Washburn—E. R. Hering, Shell Lake
Washington—S. J. Driessel, Barton
Waukesha—F. J. Woodhead, Waukesha; J. F. Wilkinson, Oconomowoc
Waupaca—A. M. Christofferson, Waupaca
Waushara—G. L. Karnopp, Wautoma
Winnebago—W. N. Linn, Oshkosh; E. B. Pfefferkorn, Oshkosh; T. D. Smith, Neenah.
Wood—F. X. Pomainville, Wisconsin Rapids; L. A. Copps, Marshfield

Milwaukee County—
First Ward—G. F. A. Fitzgerald
Second Ward—A. M. Bodden
Third Ward—Charles Fidler
Fourth Ward—C. J. Crottier
Fifth Ward—Joseph Lettenberger
Sixth Ward—Edward Jackson
Seventh Ward—C. H. Baumgart
Eighth Ward—E. J. Panetti
Ninth Ward—G. E. Collentine
Tenth Ward—J. A. Heraty
Eleventh Ward—H. J. Gramling
Twelfth Ward—A. A. Krygier
Thirteenth Ward—L. L. Allen
Fourteenth Ward—W. P. Zmyslony
Fifteenth Ward—H. J. Cannon
Sixteenth Ward—Dirk Bruins
Seventeenth Ward—E. X. Thompson
Eighteenth Ward—J. J. Pink
Nineteenth Ward—W. F. Grotjan
Twentieth Ward—E. L. Bernhart
Twenty-first Ward—Albert Popp
Twenty-second Ward—Paul W. Currer
Twenty-third Ward—P. L. Callan
Twenty-fourth Ward—E. A. Brzezinski
Twenty-fifth Ward—J. A. Davies
Twenty-sixth Ward—J. A. Froelich
Twenty-seventh Ward—J. J. Adamkiewicz
West Allis, wards 2, 3, and 4—R. H. Frederick
West Allis, ward 1; West Milwaukee, Franklin and Greenfield Towns—E. D. Wilkinson
Cudahy and Town of Lake—Bernard Krueger
South Milwaukee and Towns of Oak Creek and Franklin—George Dempsey
Whitefish Bay, Shorewood, Fox Point and Towns of Granville and Milwaukee—J. S. Gordon
Wauwatosa and Town of Wauwatosa—E. J. Carey

Medical Advisory Boards

BOARD NO. 1

Local boards served.—*Milwaukee city, local boards nos. 1, 2, 3, 4, 6, 10, 15, 16, 19*

Headquarters.—*Milwaukee*

T. J. Howard, Milwaukee; J. E. Mulsow, Milwaukee; H. C. Schumm, Milwaukee; C. A. Evans, Milwaukee; John L. Garvey, Milwaukee; G. H. Hansmann, Milwaukee; J. E. Habbe, Milwaukee; J. J. Tolan, Milwaukee (dentist)

BOARD NO. 2

Local boards served.—*Milwaukee city, local boards nos. 7, 9, 13, 18, 20, 21, 22, 25, 26 (North Side)*

Headquarters.—*Milwaukee*

W. J. Egan, Milwaukee; John B. Hitz, Milwaukee; W. P. Blount, Milwaukee; C. M. Echols, Milwaukee; R. E. Fitzgerald, Milwaukee; Norbert Enzer, Milwaukee; S. A. Morton, Milwaukee; Robert Phelan, Milwaukee (dentist)

BOARD NO. 3

Local boards served.—*Milwaukee city, local boards nos. 5, 8, 11, 12, 14, 17, 23, 24, 27 (South Side)*

Headquarters.—*Milwaukee*

Joseph Lettenberger, Milwaukee; W. E. Grove, Milwaukee; J. O. Dieterle, Milwaukee; U. A. Schlueter, Milwaukee; W. L. Herner, Milwaukee; H. K. B. Allebach, Milwaukee; P. S. Epperson, Milwaukee; R. J. Stollenwerk, Milwaukee (dentist)

BOARD NO. 4

Local boards served.—*Milwaukee county outside city limits of Milwaukee, Waukesha, Ozaukee*

Headquarters.—*Milwaukee*

Millard Tufts, Whitefish Bay; U. J. Durner, Thiensville; J. Francis Wilkinson, Oconomowoc; Dexter H. Witte, Whitefish Bay; M. Q. Howard, Wauwatosa; E. L. Tharinger, Wauwatosa; Hans W. Hefke, West Allis; A. T. Wiebrecht, Wauwatosa (dentist)

BOARD NO. 5

Local boards served.—*Walworth, Racine, Kenosha*

Headquarters.—*Racine*

H. B. Keland, Racine; T. W. Ashley, Kenosha; F. C. Christensen, Racine; Russell M. Kurten, Racine; S. G. Meany, East Troy; C. E. Pechous, Kenosha; I. E. Bowing, Kenosha; E. W. Goelz, Whitewater (dentist)

BOARD NO. 6

Local boards served.—*Jefferson, Rock, Green, and Lafayette*

Headquarters.—*Janesville*

Emmett W. Bowen, Watertown; A. H. Pember, Janesville; T. J. Snodgrass, Janesville; W. A. Munn, Janesville; N. E. Bear, Monroe; W. J. Allen, Beloit; R. F. Wilson, Beloit; W. H. McWilliams, Darlington (dentist)

BOARD NO. 7

Local boards served.—*Dane, Iowa, Grant, Columbia, Sauk, and Richland*

Headquarters.—*Madison*

Joseph S. Evans, Madison; Eugene Neff, Madison; J. W. MacGregor, Portage; A. R. Tormey, Madison; A. W. Bryan, Madison; W. D. Stovall, Madison; Ivan Ellis, Madison; A. R. Dipple, Baraboo (dentist)

BOARD NO. 8

Local boards served.—*Crawford, Vernon, Juneau, Monroe, La Crosse, Jackson, and Trempealeau*

Headquarters.—*La Crosse*

R. L. MacCornack, Whitehall; F. A. Douglas, La Crosse; Brand Starnes, New Lisbon; M. A. McGarty, La Crosse; W. E. Bannen, La Crosse; Alf H. Gundersen, La Crosse; J. E. McLoone, La Crosse; S. F. Donovan, Tomah (dentist)

BOARD NO. 9

Local boards served.—*Eau Claire, Buffalo, Pepin, Dunn, St. Croix, and Pierce*

Headquarters.—*Eau Claire*

J. W. Livingstone, Hudson; F. S. Cook, Eau Claire; F. G. Anderson, Eau Claire; Nels Werner, Eau Claire; E. O. Niver, Eau Claire; J. C. Baird, Eau Claire; C. A. Dawson, River Falls; E. H. Parish, Durand (dentist)

BOARD NO. 10

Local boards served.—*Chippewa, Rusk, and Barron*

Headquarters.—*Chippewa Falls*

D. L. Dawson, Rice Lake; Merton Field, Chippewa Falls; W. F. O'Connor, Ladysmith; F. T. McHugh, Chippewa Falls; A. L. Beier*, Chippewa Falls; J. A. Kelly, Chippewa Falls; S. E. Williams, Chippewa Falls; T. J. Cornwall, Rice Lake (dentist)

BOARD NO. 11

Local boards served.—*Polk, Burnett, Washburn, Douglas, and Sawyer*

Headquarters.—*Superior*

V. E. Ekblad, Superior; E. A. Myers, Superior; R. G. Arveson, Frederic; T. J. O'Leary, Superior; C. H. Christiansen, Superior; L. O. Simenstad, Osceola; J. R. McNutt, Superior; H. C. Greve, Hayward (dentist)

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* Deceased.

BOARD NO. 12

Local boards served.—*Bayfield, Ashland, Iron, Vilas, and Price*

Headquarters.—*Ashland*

J. W. Prentice, Ashland; R. O. Grigsby, Ashland; W. J. Tucker, Ashland; J. M. Dodd, Sr., Ashland; Fred G. Johnson, Iron River; Frank D. Weeks, Ashland; J. D. Leahy, Park Falls; F. H. Simerson, Phillips (dentist)

BOARD NO. 13

Local boards served.—*Lincoln, Taylor, Clark, Wood, Marathon, and Portage*

Headquarters.—*Wausau*

E. P. Crosby, Stevens Point; J. K. Trumbo, Wausau; Merritt L. Jones, Wausau; K. A. Morris, Merrill; E. E. Flemming, Wausau; Harold Fehland, Wausau; R. P. Potter, Marshfield; C. N. Bennett, Wisconsin Rapids (dentist)

BOARD NO. 14

Local boards served.—*Forest, Florence, Oneida, and Langlade*

Headquarters.—*Rhinelander*

J. W. Lambert, Antigo; A. F. S. Harter, Rhinelander; C. A. Richards, Rhinelander; W. P. Curran, Antigo; T. G. Torpy, Minocqua; I. E. Schiek, Rhinelander; E. G. Ovitz, Laona; O. N. Treweck, Rhinelander (dentist)

BOARD NO. 15

Local boards served.—*Marinette, Oconto, Brown, Door, and Kewaunee*

Headquarters.—*Green Bay*

M. D. Bird, Marinette; E. G. Nadeau, Green Bay; Ralph M. Carter, Green Bay; A. J. McCarey,

Board No. 15—continued

Green Bay; L. D. Quigley, Green Bay; J. L. Ford, Green Bay; L. E. Dockry, Kewaunee; R. J. Gordon, Sturgeon Bay (dentist)

BOARD NO. 16

Local boards served.—*Shawano, Waupaca, Outagamie, Calumet, and Manitowoc*

Headquarters.—*Appleton*

V. F. Marshall, Appleton; A. E. Rector, Appleton; L. J. Moriarty, Two Rivers; J. B. MacLaren, Appleton; N. J. Knauf, Chilton; George T. Hegner, Appleton; E. C. Cary, Reedsville; A. J. Zimmer, Manitowoc (dentist)

BOARD NO. 17

Local boards served.—*Adams, Waushara, Winnebago, and Marquette*

Headquarters.—*Oshkosh*

J. W. Lockhart, Oshkosh; D. G. Hugo, Oshkosh; F. G. Connell, Oshkosh; George V. Lynch, Oshkosh; J. M. Conley, Oshkosh; Burton Clark, Oshkosh; A. G. Koehler, Oshkosh; G. A. Stratton, Oshkosh (dentist)

BOARD NO. 18

Local boards served.—*Green Lake, Dodge, Washington, Sheboygan, and Fond du Lac*

Headquarters.—*Fond du Lac*

A. H. Heidner, West Bend; A. G. Hough, Beaver Dam; H. E. Twohig, Fond du Lac; S. E. Gavin, Fond du Lac; H. C. Werner, Fond du Lac; J. C. Devine, Fond du Lac; R. R. Dalrymple, Fond du Lac; J. S. Hollingsworth, Sheboygan (dentist)

Physician-Members of District Appeal Boards

First district.—*Milwaukee county:* Robert W. Blumenthal, Milwaukee

Second district.—*Milwaukee county:* Francis D. Murphy, Wauwatosa

Third district.—*Walworth, Kenosha, Racine, Waukesha, Washington, Ozaukee and Dodge counties:* E. S. Elliott, Fox Lake

Fourth district.—*Rock, Green, Lafayette, Iowa, Adams, Sauk, Columbia, Dane, Grant, Jefferson, and Marquette counties:* James A. Jackson, Madison

Fifth district.—*La Crosse, Monroe, Juneau, Vernon, Crawford and Richland counties:* B. I. Pippin, Richland Center

Sixth district.—*Jackson, Pepin, Trempealeau, Buffalo, Pierce, St. Croix, Dunn, Eau Claire, Chippewa, Barron, Polk, Clark and Rusk counties:* F. E. Butler, Menomonie

Seventh district.—*Douglas, Burnett, Washburn, Bayfield, Sawyer, Ashland, Iron, Price and Vilas counties:* C. J. Smiles, Ashland

Eighth district.—*Oneida, Forest, Langlade, Lincoln, Taylor, Marathon, Wood, Portage, Waupaca, and Shawano counties:* F. H. Kelley, Merrill

Ninth district.—*Door, Kewaunee, Brown, Oconto, Outagamie, Marinette, and Florence counties:* F. C. Huff, Sturgeon Bay

Tenth district.—*Calumet, Green Lake, Winnebago, Fond du Lac, Waushara, Sheboygan, and Manitowoc counties:* Curtis L. MacCollum, Manitowoc

Constitution and By-Laws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the material interests of its members and to protect them against imposition; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies who have been certified to the headquarters of this Society, and whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the prerequisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a member-

* As revised by the 1940 House of Delegates.

ship of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society, shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. No address or paper, except those of the president, the president-elect, and the annual orations, shall occupy more than twenty minutes in its delivery. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes at any one time.

SEC. 3. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

SEC. 3. One fourth of the members of the House of Delegates registered shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the State into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a committee on nominations consisting of one delegate from each councilor district. The committee on nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the State and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice speaker shall officiate during the unexpired term.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily during the session and at such other times as necessity may require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting during January for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members to be known as a Committee on Auditing and Finance, shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council in January of each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

A Council on Scientific Work.
A Committee on Public Policy.
A Committee on Grievances.
A Committee on Cancer.
A Committee on Medical Education and Hospitals.
A Committee on Medical Economics.
A Committee on Maternal and Child Welfare.
A Committee on Health and Public Instruction.
A Committee on Coordination of Medical Services.
A Committee on Care of Crippled Children.
A Committee on Goiter.
A Committee on Visual and Hearing Defects.
A Committee on Mental Hygiene and Institutional Care.
A Committee Advisory to the Woman's Auxiliary.
A Committee on Tuberculosis and Chest Diseases.
A Committee on Industrial Health.

Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for a term of three years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, and three years, and thereafter for terms of three years each.

SEC. 2. The Council on Scientific Work shall consist of five members, and each member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Committee on Public Policy shall consist of three members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 4. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice.

SEC. 5. The Committee on Medical Education and Hospitals shall serve in this State for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

SEC. 6. The Committee on Medical Economics shall investigate matters affecting the economic status of physicians as a profession, and shall report annually to the House of Delegates such recommendations as may, in its judgment, seem proper.

SEC. 7. The Committee on Maternal and Child Welfare shall consist of six members and its principal duties shall be to advise cooperating agencies in the effort to reduce maternal mortality and to preserve child health.

SEC. 8. The Committee on Health and Public Instruction shall consist of three members. It shall carry on such activities in the field of health and the dissemination of information in relation thereto as the House of Delegates and Council may direct.

SEC. 9. The Committee on Care of Crippled Children shall consist of six members, and its principal duty shall be to act in an advisory capacity to state departments concerned with the subject matter.

SEC. 10. The Committee on Goiter shall consist of three members, and its principal duty shall be to forward those measures looking toward the prevention of goiter, and where existent, its early diagnosis and treatment.

SEC. 11. The Committee on Visual and Hearing Defects shall consist of three members, and its principal duties shall lie in the field of prevention, and where existent, early discovery and treatment. It shall act in an advisory capacity to state departments concerned with these problems.

SEC. 12. The Committee on Mental Hygiene and Institutional Care shall consist of three members, and its principal duties shall be advisory to both the Society and cooperating agencies as to those means best designed to protect mental health and to alleviate mental illnesses.

SEC. 13. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past-president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 14. The Committee on Tuberculosis and Chest Diseases shall consist of three members, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of tuberculosis and diseases of the chest.

SEC. 15. The Committee on Industrial Health shall consist of three members, and its principal duties shall be to cooperate with the Council on Industrial Health of the American Medical Association, and to seek to further the health of those employed in industry in Wisconsin.

SEC. 16. Reports of the standing and special committees shall be published in the official Journal preceding the date of the annual session of this Society, and these reports must be in the hands of the secretary sixty days in advance of the annual session.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

When a member shall have paid his dues for thirty-five years, upon request of his county medical society, he may become a life member and shall then be exempt from the payment of further dues and a certificate of membership shall be issued to such member annually.

SEC. 2. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 3. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a citizen of the United States and who is a bona fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year,

with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this State, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. At some meeting in advance of the annual session of this Society, each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committee-men shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

CHAPTER XII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

CHAPTER XIII

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid on the table for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

Principles of Medical Ethics of the American Medical Association

CHAPTER I

IN GENERAL

THE PHYSICIAN'S RESPONSIBILITY

SECTION 1.—A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals.

GROUPS AND CLINICS

SEC. 2.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual doctors each of whom whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

CHAPTER II

THE DUTIES OF PHYSICIANS TO THEIR PATIENTS

PATIENCE, DELICACY AND SECRECY

SECTION 1.—Patience and delicacy should characterize all the acts of a physician. The confidences concerning individual or domestic life entrusted by a patient to a physician and the defects of disposition or flaws of character observed in patients during medical attendance should be held as a trust and should never be revealed except when imperatively required by the laws of the state. There are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected, because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would desire another to act toward one of his own family under like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 2.—A physician should give timely notice of dangerous manifestations of the disease to the friends of the patient. He should neither exaggerate nor minimize the gravity of the patient's condition. He should assure himself that the patient or his friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

PATIENTS MUST NOT BE NEGLECTED

SEC. 3.—A physician is free to choose whom he will serve. He should, however, always respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, a physician should not abandon or neglect the patient because the disease is deemed incurable; nor should he withdraw from the case for any reason until a sufficient notice of a desire to be released has been given the patient or his friends to make it possible for them to secure another medical attendant.

CHAPTER III

THE DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLD HONOR OF PROFESSION

SECTION 1.—The obligation assumed on entering the profession requires the physician to comport himself as a gentleman and demands that he use every honorable means to uphold the dignity and honor of his vocation, to exalt its standards and to extend its sphere of usefulness. A physician should not base his practice on an exclusive dogma or sectarian system, for "sects are implacable despots; to accept their thraldom is to take away all liberty from one's action and thought." (Nicon, father of Galen.)

MEDICAL SOCIETIES

SEC. 2.—In order that the dignity and honor of the medical profession may be upheld, its standards exalted, its sphere of usefulness extended, and the advancement of medical science promoted, a physician should associate himself with medical societies and contribute his time, energy and means in order that these societies may represent the ideals of the profession.

DEPORTMENT

SEC. 3.—A physician should be "an upright man, instructed in the art of healing." Consequently, he must keep himself pure in character and conform to a high standard of morals, and must be diligent and conscientious in his studies. "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life." (Hippocrates.)

ADVERTISING

SEC. 4.—Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not *per se* improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients.

PATENTS AND PERQUISITES

SEC. 5.—It is unprofessional to receive remuneration from patents or copyrights on surgical instruments, appliances, medicines, foods, methods or procedures. It is equally unprofessional by ownership or control of patents or copyrights either to retard or to inhibit research or to restrict the benefit to patients or to the public to be derived therefrom. It is unprofessional to accept rebates on prescriptions or appliances, or perquisites from attendants who aid in the care of patients.

MEDICAL LAWS—SECRET REMEDIES

SEC. 6.—It is unprofessional for a physician to assist unqualified persons to evade legal restrictions governing the practice of medicine; it is equally unethical to prescribe or dispense secret medicines or other secret remedial agents, or manufacture or promote their use in any way.

SAFEGUARDING THE PROFESSION

SEC. 7.—Physicians should expose without fear or favor, before the proper medical or legal tribunals, corrupt or dishonest conduct of members of the profession. All questions affecting the professional reputation or standing of a member or members of the medical profession should be considered only before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations. Every physician should aid in safeguarding the profession against the admission to its ranks of those who are unfit or unqualified because deficient either in moral character or education.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

PHYSICIANS DEPENDENT ON EACH OTHER

SECTION 1.—Experience teaches that it is unwise for a physician to treat members of his own family or himself. Consequently, a physician should always cheerfully and gratuitously respond with his professional services to the call of any physician practicing in his vicinity, or of the immediate family dependents of physicians.

COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called on to advise another physician or one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss should, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN TO TAKE CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select a physician from among his neighing colleagues to take charge of the case. Other physicians may be associated in the care of the patient as consultants.

ARTICLE III.—DUTIES OF PHYSICIAN IN CONSULTATIONS

CONSULTATIONS SHOULD BE ENCOURAGED

SECTION 1.—In serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to be derived by the patient is of first importance. All the physicians interested in the case should be frank and candid with the patient and his family. There never is occasion for insincerity, rivalry or envy and these should never be permitted between consultants.

PUNCTUALITY

SEC. 3.—It is the duty of a physician, particularly in the instance of a consultation, to be punctual in attendance. When, however, the consultant

or the physician in charge is unavoidably delayed, the one who first arrives should wait for the other for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or if it be the desire of the patient, he may examine the patient and mail his written opinion, or see that it is delivered under seal, to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO SPECIALIST

SEC. 4.—When a patient is sent to one specially skilled in the care of the condition from which he is thought to be suffering, and for any reason it is impracticable for the physician in charge of the case to accompany the patient, the physician in charge should send to the consultant by mail, or in the care of the patient under seal, a history of the case, together with the physician's opinion and an outline of the treatment, or so much of this as may possibly be of service to the consultant; and as soon as possible after the case has been seen and studied, the consultant should address the physician in charge and advise him of the results of the consultant's investigation of the case. Both these opinions are confidential and must be so regarded by the consultant and by the physician in charge.

DISCUSSIONS IN CONSULTATION

SEC. 5.—After the physicians called in consultation have completed their investigations of the case, they should meet by themselves to discuss conditions and determine the course to be followed in the treatment of the patient. No statement or discussion of the case should take place before the patient or friends, except in the presence of all the physicians attending or by their common consent; and no opinions or prognostications should be delivered as a result of the deliberations of the consultants, which have not been concurred in by the consultants at their conference.

ATTENDING PHYSICIAN RESPONSIBLE

SEC. 6.—The physician in attendance is in charge of the case and is responsible for the treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the mode of treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, at the next consultation, he should state his reasons for departing from the course decided on at the previous conference. When an emergency occurs during the absence of the attending physician, a consultant may provide for the emergency and the subsequent care of the patient until the arrival of the physician in charge, but should do no more than this without the consent of the physician in charge.

CONFLICT OF OPINION

SEC. 7.—Should the attending physician and the consultant find it impossible to agree in their view of a case another consultant should be called to the conference or the first consultant should withdraw. However, since the consultant was employed by the patient in order that his opinion might be obtained, he should be permitted to state the result of his study of the case to the patient, or his next friend in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has attended a case as a consultant, he should not become the attendant of the patient during that illness except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SECTION 1.—The physician, in his intercourse with a patient under the care of another physician, should observe the strictest caution and reserve; should give no disingenuous hints relative to the nature and treatment of the patient's disorder; nor should the course of conduct of the physician, directly or indirectly, tend to diminish the trust reposed in the attending physician. In embarrassing situations, or wherever there may seem to be a possibility of misunderstanding with a colleague, the physician should always seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

SEC. 2.—A physician should avoid making social calls on those who are under the professional care of other physicians without the knowledge and consent of the attendant. Should such a friendly visit be made, there should be no inquiry relative to the nature of the disease or comment upon the treatment of the case, but the conversation should be on subjects other than the physical condition of the patient.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should never take charge of or prescribe for a patient who is under the care of another physician, except in an emergency, until after the other physician has relinquished the case or has been properly dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in the charge of a case, he should not make comments on or insinuations regarding the practice of the one who preceded him. Such com-

ments or insinuations tend to lower the esteem of the patient for the medical profession and so react against the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency and finds that he has been sent for because the family attendant is not at hand, or when a physician is asked to see another physician's patient because of an aggravation of the disease, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the family physician after he has reported the condition found and the treatment administered.

WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident the first to arrive should be considered the physician in charge. However, as soon as the exigencies of the case permit, or on the arrival of the acknowledged family attendant or the physician the patient desires to serve him, the first physician should withdraw in favor of the chosen attendant; should the patient or his family wish some one other than the physician known to be the family physician to take charge of the case the patient should advise the family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital, the patient should be returned to the care of his known family physician as soon as the condition of the patient and the circumstances of the case warrant this transfer.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during his temporary absence, or when, because of an emergency, he is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy as he would have one of his own patients cared for under similar circumstances. The patient should be returned to the care of the attending physician as soon as possible.

RELINQUISHING PATIENT TO REGULAR ATTENDANT

SEC. 8.—When a physician is called to the patient of another physician during the enforced absence of that physician, the patient should be relinquished on the return of the latter.

SUBSTITUTING IN OBSTETRIC WORK

SEC. 9.—When a physician attends a woman in labor in the absence of another who has been engaged to attend, such physician should resign the patient to the one first engaged, upon his arrival; the physician is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DIFFERENCES BETWEEN PHYSICIANS

ARBITRATION

SECTION 1.—Whenever there arises between physicians a grave difference of opinion which cannot be promptly adjusted, the dispute should be referred for arbitration to a committee of impartial physicians, preferably the Board of Censors of a component county society of the American Medical Association.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SECTION 1.—The poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for unremunerated services.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

CONTRACT PRACTICE

SEC. 3.—By the term "contract practice" as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, to furnish partial or full medical services to a group or class of individuals on the basis of a fee schedule, or for a salary or a fixed rate per capita.

Contract practice *per se* is not unethical. However, certain features or conditions if present make a contract unethical, among which are: (1) When there is solicitation of patients, directly or indirectly. (2) When there is underbidding to secure the contract. (3) When the compensation is inadequate to assure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of a physician is prevented. (6) When the conditions of employment make it impossible to render adequate service to the patients. (7) When the contract because of any of its provisions or practical results is contrary to sound public policy. The phrase "free choice of physician," as applied to contract practice, is defined to mean that degree of freedom in choosing a physician which can be exercised under usual conditions

of employment between patient and physician when no third party has a valid interest or intervenes. The interjection of a third party who has a valid interest or who intervenes does not *per se* cause a contract to be unethical. A "valid interest" is one where, by law or necessity, a third party is legally responsible either for cost of care or for indemnity. "Intervention" is the voluntary assumption of partial or full financial responsibility for medical care. Intervention shall not proscribe endeavor by component or constituent medical societies to maintain high quality of service rendered by members serving under approved sickness service agreements between such societies and governmental boards or bureaus and approved by the respective societies.

Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole.

COMMISSIONS

SEC. 4.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or to receive a commission by whatever term it may be called or under any guise or pretext whatsoever.

DIRECT PROFIT TO LAY GROUPS

SEC. 5.—It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary, or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.

CHAPTER IV

THE DUTIES OF THE PROFESSION TO THE PUBLIC

PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens and because their professional training specially qualifies them to render this service, should give advice concerning the public health of the community. They should bear their full part in enforcing its laws and sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations. They should be ready to counsel the public on subjects relating to sanitary police, public hygiene and legal medicine.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public regarding quarantine regulations; on the location, arrangement and dietaries of hospitals, asylums, schools, prisons and similar institutions; and concerning measures for the prevention of epidemic and contagious diseases. When an epidemic prevails, a physician must continue his labors for the alleviation of suffering people, without regard to the risk to his own health or life or to financial return. At all times, it is the duty of the physician to notify the properly constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities of the locality in which the patient is.

PUBLIC WARNED

SEC. 3—Physicians should warn the public against the devices practiced and the false pretentions made by charlatans which may cause injury to health and loss of life.

PHARMACISTS

SEC. 4. — By legitimate patronage, physicians should recognize and promote the profession of pharmacy; but any pharmacist, unless he be qualified as a physician, who assumes to prescribe for the sick, should be denied such countenance and support. Moreover, whenever a druggist or pharmacist dispenses deteriorated or adulterated drugs, or substitutes one remedy for another designated in a prescription, he thereby forfeits all claims to the favorable consideration of the public and physicians.

CONCLUSION

While the foregoing statements express in a general way the duty of the physician to his patients, to other members of the profession and to the profession at large, as well as of the profession to the public, it is not to be supposed that they cover the whole field of medical ethics, or that the physician is not under many duties and obligations besides these herein set forth. In a word, it is incumbent on the physician that under all conditions, his bearing toward patients, the public and fellow practitioners should be characterized by a gentlemanly deportment and that he constantly should behave toward others as he desires them to deal with him. Finally, these principles are primarily for the good of the public, and their enforcement should be conducted in such a manner as shall deserve and receive the endorsement of the community.

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(Dr. S. E. Gavin, Fond du Lac, Chairman)

First: Dodge, Jefferson and Waukesha County Societies. Dr. H. P. Bowen, Watertown, 1942.

Second: Kenosha, Racine and Walworth County Societies. Dr. C. E. Pechous, 625 Fifty-seventh Street, Kenosha, 1942.

Third: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies. Dr. W. T. Clark, 20 East Milwaukee Street, Janesville, 1943.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. B. I. Pippin, Richland Center, 1943.

Fifth: Calumet, Manitowoc, Sheboygan and Washington–Ozaukee County Societies. Dr. A. H. Heidner, West Bend, 1943.

Sixth: Brown–Kewaunee–Door, Fond du Lac, Outagamie and Winnebago County Societies. Dr. S. E. Gavin (chairman), 104 South Main Street, Fond du Lac, 1943.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. Dr. H. A. Jegi, Galesville, 1941.

Eighth: Marinette–Florence, Oconto and Shawano County Societies. Dr. G. W. Krahn, Oconto Falls, 1941.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. Dr. H. H. Christofferson, Colby, 1941.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. Dr. F. E. Butler, Menomonie, 1941.

Eleventh: Ashland–Bayfield–Iron and Douglas County Societies. Dr. F. G. Johnson, Iron River, 1942.

Twelfth: The Medical Society of Milwaukee County. Dr. H. J. Gramling, 2740 West Forest Home Avenue, Milwaukee, 1942; Dr. R. E. Fitzgerald, 2750 North Teutonia Avenue, Milwaukee, 1942; Dr. Robert W. Blumenthal, 411 East Mason Street, Milwaukee, 1943.

Thirteenth: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Dr. J. W. Lambert, Antigo, 1941.

Dr. R. G. Arveson (Past-President), Frederic, 1941.

Delegates to American Medical Association

Dr. S. E. Gavin (1942)
104 South Main Street
Fond du Lac

Dr. J. C. Sargent (1942)
324 East Wisconsin Avenue
Milwaukee

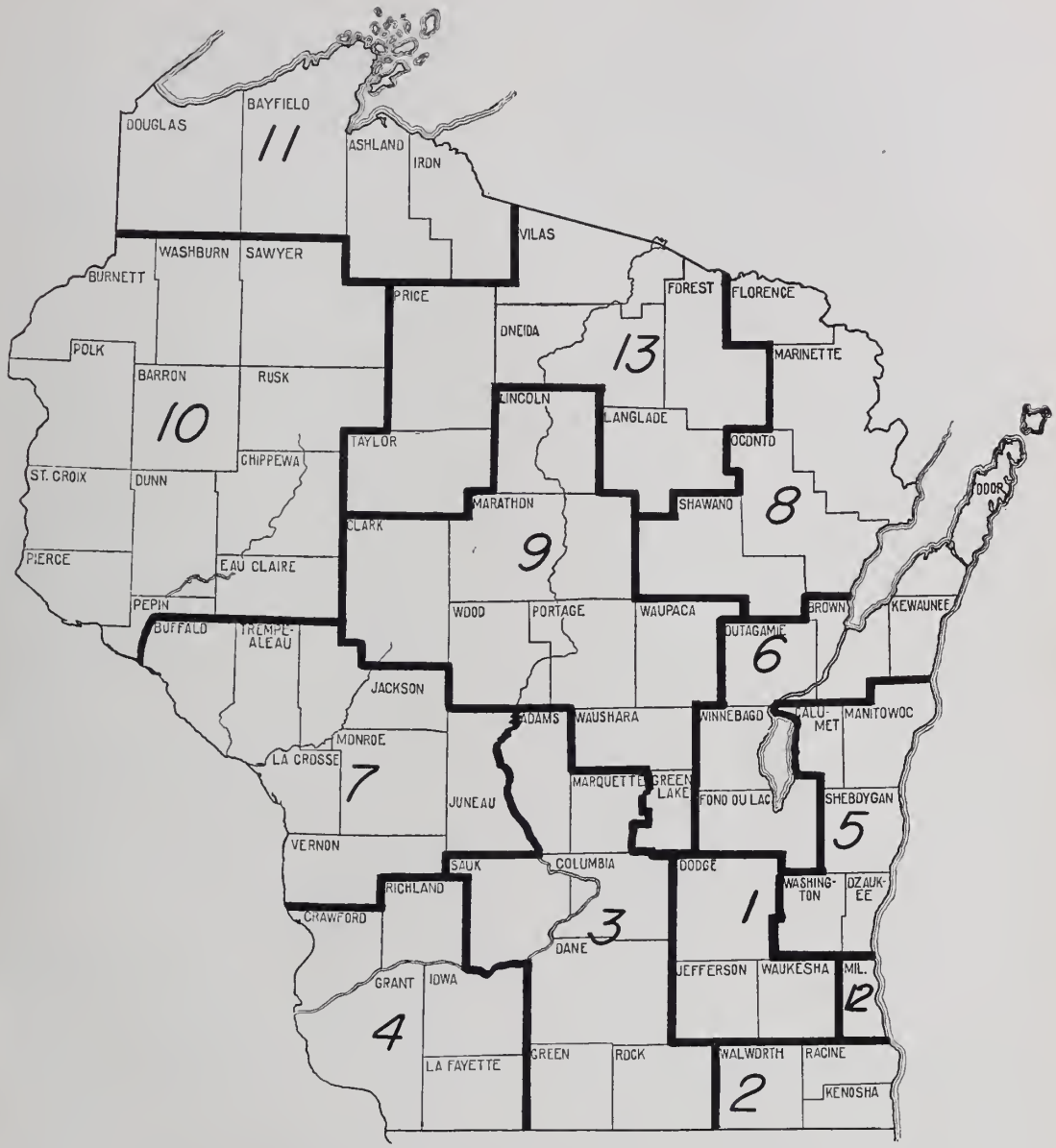
Dr. J. F. Smith (1941)
605½ Third Street
Wausau

Alternates

Dr. S. J. Seeger (1942)
324 East Wisconsin Avenue
Milwaukee

Dr. F. E. Butler (1942)
Menomonie

Dr. C. W. Giesen (1941)
1507 Tower Avenue
Superior



MAP INDICATING LOCATION OF COUNCILOR DISTRICTS

First District:
Dr. H. P. Bowen, Watertown

Second District:
Dr. C. E. Pechous, Kenosha

Third District:
Dr. W. T. Clark, Janesville

Fourth District:
Dr. B. I. Pippin, Richland Center

Fifth District:
Dr. A. H. Heidner, West Bend

Sixth District:
Dr. S. E. Gavin, Chairman
Fond du Lac

Seventh District:
Dr. H. A. Jegi, Galesville

Eighth District:
Dr. G. W. Krahn, Oconto Falls

Ninth District:
Dr. H. H. Christofferson, Colby

Tenth District:
Dr. F. E. Butler, Menomonie

Eleventh District:
Dr. F. G. Johnson, Iron River

Twelfth District:
Dr. H. J. Gramling, Milwaukee
Dr. R. E. Fitzgerald, Milwaukee
Dr. Robert W. Blumenthal, Milwaukee

Thirteenth District:
Dr. J. W. Lambert, Antigo

STANDING COMMITTEES

The Committee on Cancer

Dr. Charles Fidler, 1943, chairman, 231 West Wisconsin Avenue, Milwaukee
Dr. Marcos Fernan–Nunez, 1941, 561 North Fifteenth Street, Milwaukee
Dr. R. L. Alvarez, 1941, Galesville
Dr. H. L. Schwartz, 1941, 625 Fifty-seventh Street, Kenosha
Dr. H. H. Morton, 1941, Dodgeville
Dr. C. A. Richards, 1941, Rhinelander
Dr. E. E. Evenson, 1942, Wittenberg
Dr. R. C. Thompson, 1941, Cumberland
Dr. J. W. McGill, 1942, 1225 Tower Avenue, Superior
Dr. E. F. Schneiders, 1943, 113 North Carroll Street, Madison
Dr. T. A. Teitgen, 1943, 927 South Eighth Street, Manitowoc
Dr. Erich Wisiol, 1943, 441 Main Street, Stevens Point
Dr. G. E. Eck, 1942, Lake Mills
Dr. D. J. Twohig, 1942, 11 North Main Street, Fond du Lac

The Advisory Committee on Care of Crippled Children

Dr. H. K. Tenney, 1942, chairman, 1 South Pinckney Street, Madison
Dr. J. B. MacLaren, 1941, 120 South Oneida Street, Appleton
Dr. H. L. Greene, 1941, 1 South Pinckney Street, Madison
Dr. John O. Dieterle, 1943, 425 East Wisconsin Avenue, Milwaukee
Dr. Herman Schumm, 1943, 425 East Wisconsin Avenue, Milwaukee
Dr. C. M. Kurtz, 1942, 1300 University Avenue, Madison

The Committee on Coordination of Medical Services

Dr. Millard Tufts, 1943, chairman, 208 East Wisconsin Avenue, Milwaukee
Dr. S. E. Gavin, 1942, 104 South Main Street, Fond du Lac
Dr. L. V. Sprague, 1941, 2520 East Washington Avenue, Madison
President, ex officio
Secretary, ex officio

The Committee on Goiter

Dr. O. R. Lillie, 1943, chairman, 208 East Wisconsin Avenue, Milwaukee
Dr. Arnold S. Jackson, 1942, 16 South Henry Street, Madison
Dr. J. M. Johnson, 1941, Ripon
Dr. E. L. Sevringhaus, ex officio, 1300 University Avenue, Madison
Dr. C. N. Neupert, ex officio, State Office Building, Madison

The Committee on Grievances

Dr. W. A. Ryan, 1943, chairman, 709 North Eleventh Street, Milwaukee
Dr. A. J. Patek, 1942, 425 East Wisconsin Avenue, Milwaukee
Dr. R. M. Kurten, 1941, 810 Main Street, Racine

The Committee on Health and Public Instruction

Dr. W. J. Egan, 1943, chairman, 720 North Jefferson Street, Milwaukee
Dr. F. B. Sazama, 1941, Chippewa Falls
Dr. J. A. Riegel, 1942, St. Croix Falls

The Committee on Industrial Health

Dr. S. J. Seeger, 1942, chairman, 324 East Wisconsin Avenue, Milwaukee
Dr. E. O. Gertenbach, 1941, 425 East Wisconsin Avenue, Milwaukee
(Another appointment to be made.)

The Committee on Maternal and Child Welfare

Dr. J. J. Pink, 1943, chairman, 324 East Wisconsin Avenue, Milwaukee
Dr. A. B. Schwartz, 1942, 2018 East North Avenue, Milwaukee
Dr. J. W. Harris, 1942, 1300 University Avenue, Madison
Dr. J. Gurney Taylor, 1941, 324 East Wisconsin Avenue, Milwaukee
Dr. Amy Louise Hunter, 1941, State Capitol, Madison
Dr. J. F. Wilkinson, 1943, Oconomowoc

The Committee on Medical Economics

Dr. C. W. Eberbach, chairman, 1943, 324 East Wisconsin Avenue, Milwaukee
Dr. A. S. White, 1942, Rice Lake
Dr. E. H. Spiegelberg, 1941, Boscobel

The Committee on Medical Education and Hospitals

Dr. F. D. Murphy, 1942, chairman, 536 West Wisconsin Avenue, Milwaukee
Dr. E. V. Stadel, 1941, Reedsburg
Dr. R. E. Burns, 1943, 1300 University Avenue, Madison

The Committee on Mental Hygiene and Institutional Care

Dr. G. E. Seaman, chairman, 1941, State Capitol, Madison
Dr. A. W. Bryan, 1942, 16 South Henry Street, Madison
Dr. S. K. Pollack, 1943, 208 East Wisconsin Avenue, Milwaukee

The Committee on Public Policy

Dr. C. A. Dawson, 1942, chairman, River Falls
Dr. S. E. Gavin, 1941, 104 South Main Street, Fond du Lac
Dr. J. C. Sargent, 1943, 324 East Wisconsin Avenue, Milwaukee
President, president-elect, secretary—ex officio

The Council on Scientific Work

Dr. E. J. Carey, 1941, 561 North Fifteenth Street, Milwaukee, chairman
Dr. G. W. Krahn, 1942, Oconto Falls
Dr. C. J. Smiles, 1943, Ashland
Dr. E. R. Schmidt, 1944, 1300 University Avenue, Madison
Dr. K. H. Doege, 1945, Marshfield
Dr. W. S. Middleton, 1300 University Avenue, Madison, ex officio

The Committee on Tuberculosis and Chest Diseases

Dr. A. A. Pleyte, 1942, chairman, 1018 North Jefferson Street, Milwaukee
Dr. W. T. Clark, 20 East Milwaukee Street, Janesville
Dr. L. O. Simenstad, 1943, Osceola

The Advisory Committee on Visual and Hearing Defects

Dr. J. K. Trumbo, 1941, chairman, 520 Third Street, Wausau
Dr. F. S. Cook, 1942, 131 South Barstow Street, Eau Claire
Dr. F. W. Kundert, 224 West Washington Avenue, Madison

The Advisory Committee to Woman's Auxiliary

Chairman of Council, chairman
Immediate past president
President
President-elect
Secretary

SPECIAL COMMITTEES

(Appointed annually by the president)

The Committee on Safety on Public Highways

Dr. M. W. Sherwood, chairman, 238 West Wisconsin Avenue, Milwaukee
Dr. H. A. Heise, 425 East Wisconsin Avenue, Milwaukee
Dr. J. J. Boersma, 1001 North Eighth Street, Sheboygan

The Committee on Venereal Diseases

Dr. H. R. Foerster, chairman, 208 East Wisconsin Avenue, Milwaukee
Dr. Gunnar Gundersen, 1836 South Avenue, La Crosse
Dr. Norbert Enzer, 425 East Wisconsin Avenue, Milwaukee
Dr. Conrad W. Giesen, 1514 Ogden Avenue, Superior
Dr. N. Warren Bourne, 208 East Wisconsin Avenue, Milwaukee

The Special Committee on Voluntary Sickness Insurance

Dr. C. D. Neidhold, 103 West College Avenue, Appleton
Dr. W. M. Nesbit, 1 South Pinckney Street, Madison
Dr. D. H. Witte, 3405 West Lisbon Avenue, Milwaukee

Centennial Committees

Dr. A. S. Jackson, general centennial chairman, 16 South Henry Street, Madison

Assistants

Dr. D. L. Williams, 16 North Carroll Street, Madison
Dr. L. E. Holmgren, 16 South Henry Street, Madison
H. W. Virgin, 122 West Washington Avenue Madison

Advisory Committee

Dr. R. P. Sproule, chairman, 208 East Wisconsin Avenue, Milwaukee
Dr. R. G. Arveson, Frederic
Dr. Gunnar Gundersen, 1836 South Avenue, La Crosse
Dr. E. J. Carey, 561 North Fifteenth Street, Milwaukee
Dr. W. S. Middleton, 1300 University Avenue, Madison

Executive Committee

Dr. A. G. Sullivan, chairman, 16 North Carroll Street, Madison
Dr. J. P. Dean, 113 North Carroll Street, Madison
Dr. T. W. Tormey, Sr., 16 North Carroll Street, Madison
Dr. G. H. Ewell, 16 South Henry Street, Madison
Dr. R. C. Buerki, 1300 University Avenue, Madison

Transportation

Dr. A. R. Tormey, chairman, 16 North Carroll Street, Madison
Dr. E. S. Sullivan, 16 North Carroll Street, Madison
Dr. H. E. Marsh, 16 South Henry Street, Madison
Dr. I. R. Sisk, 1 South Pinckney Street, Madison
Dr. W. J. Ganser, 119 Monona Avenue, Madison

Housing

Dr. L. V. Sprague, chairman, 2520 East Washington Avenue, Madison
Dr. H. M. Carter, 1 South Pinckney Street, Madison
Dr. A. J. Boner, 15 West Main Street, Madison
Dr. G. J. Maloof, 19 North Pinckney Street, Madison
Dr. G. A. Cooper, 110 East Main Street, Madison

(Centennial Committees—continued)

Entertainment—Music

Dr. C. K. Schubert, chairman, 1 South Pinckney Street, Madison
Dr. Louis Fauerbach, 16 North Carroll Street, Madison
Dr. D. C. Atwood, 23 South Pinckney Street, Madison
Dr. J. A. Hurlbut, 16 South Henry Street, Madison
Dr. E. M. Juster, 130 State Street, Madison

Wednesday Evening Program

Dr. C. O. Vingom, chairman, 122 West Washington Avenue, Madison
Dr. R. M. Waters, 1300 University Avenue, Madison
Dr. H. K. Tenney, 1 South Pinckney Street, Madison
Dr. W. B. Dimond, 16 North Carroll Street, Madison
Dr. N. A. Hill, 1 South Pinckney Street, Madison

Guests

Dr. W. S. Middleton, chairman, 1300 University Avenue, Madison
Dr. R. T. Cooksey, 1 South Pinckney Street, Madison
Dr. J. A. Jackson, 16 South Henry Street, Madison
Dr. F. A. Davis, 224 West Washington Avenue, Madison
Dr. W. F. Lorenz, 1300 University Avenue, Madison
Dr. H. A. Keenan, Stoughton

Decorations

Dr. T. A. Leonard, Jr., chairman, 1 South Pinckney Street, Madison
Dr. M. J. Coluccy, 829 University Avenue, Madison
Dr. S. J. Briggs, 110 East Main Street, Madison
Dr. C. S. Harper, 1 South Pinckney Street, Madison
Dr. J. E. Gonce, 1300 University Avenue, Madison

Parking

Dr. H. L. Greene, chairman, 1 South Pinckney Street, Madison
Dr. W. M. Nesbit, 1 South Pinckney Street, Madison
Dr. K. L. Puestow, 1300 University Avenue, Madison
Dr. F. B. Taylor, 24 East Main Street, Madison
Dr. S. A. McCormick, 2609 University Avenue, Madison

Golf

Dr. J. B. Wear, chairman, 1 South Pinckney Street, Madison
Dr. E. B. Keck, 1 West Main Street, Madison
Dr. J. C. Dean, 113 North Carroll Street, Madison
Dr. V. B. Hyslop, 117 North Carroll Street, Madison
Dr. J. W. Gale, 1300 University Avenue, Madison

Press

Dr. D. L. Williams, chairman, 16 North Carroll Street, Madison
Dr. H. C. Johnson, 1 South Pinckney Street, Madison
Dr. M. H. Wirig, 122 West Washington Avenue, Madison
Dr. J. H. Lee, 119 Monona Avenue, Madison
Dr. W. H. Krehl, 102 King Street, Madison

Lay Health Exhibit

Dr. E. J. Carey, chairman, 561 North Fifteenth Street, Milwaukee
Dr. W. D. Stovall, 1300 University Avenue, Madison
Dr. F. D. Murphy, 536 West Wisconsin Avenue, Milwaukee
Dr. W. E. Meanwell, 110 East Main Street, Madison
Dr. A. S. Jackson, 16 South Henry Street, Madison

A. Exhibits

Dr. C. N. Neupert, chairman, State Office Building, Madison
Dr. F. F. Bowman, 112 North Hamilton Street, Madison
Dr. E. L. Sevringhaus, 1300 University Avenue, Madison
Dr. A. W. Bryan, 16 South Henry Street, Madison
Dr. L. V. Littig, 925 Mound Street, Madison

B. Finance

Dr. J. S. Supernaw, chairman, 1 South Pinckney Street, Madison
Dr. F. L. Weston, 1 South Pinckney Street, Madison
Dr. H. M. Kay, 905 University Avenue, Madison
Dr. W. A. Werrell, 1 West Main Street, Madison
Dr. R. L. McIntosh, 110 East Main Street, Madison

Committee on First Aid

Dr. H. C. Schumm, chairman, 425 East Wisconsin Avenue, Milwaukee
Dr. W. J. Allen, 405 East Grand Avenue, Beloit
Dr. A. J. Batty, Portage
Dr. W. H. Bennett, 611 Fifty-sixth Street, Kenosha
Dr. G. H. Benson, Richland Center

(Committee on First Aid—continued)

Dr. W. P. Blount, 324 East Wisconsin Avenue, Milwaukee
Dr. F. E. Brinckerhoff, 419 Pleasant Street, Beloit
Dr. W. S. Bump, Rhinelander
Dr. F. E. Butler, Menomonie
Dr. R. M. Carter, 122 East Walnut Street, Green Bay
Dr. W. F. Cowan, 457½ Main Street, Stevens Point
Dr. Wilson Cunningham, Platteville
Dr. J. O. Dieterle, 425 East Wisconsin Avenue, Milwaukee
Dr. D. L. Dawson, Rice Lake
Dr. Victor E. Ekblad, 1507 Tower Avenue, Superior
Dr. A. C. Edwards, Baraboo
Dr. W. C. Edwards, Richland Center
Dr. Louis E. Fazen, 729 Main Street, Racine
Dr. Charles Fidler, 231 West Wisconsin Avenue, Milwaukee
Dr. S. E. Gavin, 104 South Main Street, Fond du Lac
Dr. W. B. Gnagi, Sr., Monroe
Dr. W. B. Gnagi, Jr., Monroe
Dr. M. L. Jones, 510½ Third Street, Wausau
Dr. R. M. Kurten, 810 Main Street, Racine
Dr. O. R. Lillie, 208 East Wisconsin Avenue, Milwaukee
Dr. V. F. Marshall, 103 West College Avenue, Appleton
Dr. E. L. Mason, 131 South Barstow Street, Eau Claire
Dr. A. L. Mayfield, 625 Fifty-seventh Street, Kenosha
Dr. A. T. Nadeau, 1421 Main St., Marinette
Dr. W. L. Nelson, Wisconsin Rapids
Dr. Carl von Neupert, 412 Church Street, Stevens Point
Dr. T. J. O'Leary, 1507 Tower Avenue, Superior
Dr. C. E. Pechous, 625 Fifty-seventh Street, Kenosha
Dr. C. C. Schneider, 231 West Wisconsin Avenue, Milwaukee
Dr. Irwin Schulz, 425 East Wisconsin Avenue, Milwaukee
Dr. S. J. Seeger, 324 East Wisconsin Avenue, Milwaukee
Dr. C. J. Smiles, 522 West Second Street, Ashland
Dr. J. F. Smith, 605½ Third Street, Wausau
Dr. L. D. Smith, 2454 West Kilbourn Avenue, Milwaukee
Dr. L. M. Smith, 130 Main Street, Oshkosh
Dr. T. J. Snodgrass, 500 West Milwaukee Street, Janesville
Dr. T. W. Tormey, 16 North Carroll Street, Madison
Dr. D. J. Twohig, 11 North Main Street, Fond du Lac
Dr. H. A. Vedder, Marshfield
Dr. F. D. Weeks, 522 West Second Street, Ashland
Dr. A. P. Zlatnik, 1421 Seventeenth Street, Two Rivers
Dr. P. A. Midelfart, 314 East Grand Avenue, Eau Claire

COMMITTEES OF THE COUNCIL

(Appointed in January annually by chairman of the Council)

Auditing Committee

Dr. H. H. Christofferson, Colby
Dr. G. W. Krahn, Oconto Falls
Dr. Robert W. Blumenthal, 411 East Mason Street, Milwaukee

Executive Committee

President
Chairman of Council
Treasurer
Secretary
Dr. W. T. Clark, 20 East Milwaukee Street, Janesville
Dr. A. H. Heidner, West Bend
Dr. Robert W. Blumenthal, 411 East Mason Street, Milwaukee
President-elect (ex officio)

Conference Committee on Open Panels

Representing the State Medical Society of Wisconsin
Dr. R. P. Sproule, Milwaukee, chairman
Dr. T. J. O'Leary, Superior

Representing the Association of Casualty and Surety Executives (stock insurance companies)
Mr. E. E. Langworthy, Milwaukee

Representing the American Mutual Alliance
Mr. C. W. Kroening, Wausau

Conference Committee on Wisconsin Hospitals and Medical Payments Plan

Representing the Association of Casualty and Surety Executives
Mr. E. E. Langworthy, Milwaukee, chairman
Mr. A. D. Kehoe, Milwaukee

Representing the American Mutual Alliance
Mr. C. W. Kroening, Wausau
Mr. H. J. Schroeder, Stevens Point

Representing the State Medical Society of Wisconsin
Dr. C. H. Andrew, Platteville
Dr. J. W. MacGregor, Portage

Representing the Wisconsin Hospital Association
Miss Grace Crafts, Madison

Representing the Wisconsin Conference of Catholic Hospitals
Sister Mary Bernadette, Madison

The M–Day Committee

Dr. R. E. Fitzgerald, chairman, 2750 North Teutonia Avenue, Milwaukee

Dr. J. W. Lambert, Antigo

Dr. Robert W. Blumenthal, 411 East Mason Street, Milwaukee

Mr. J. G. Crownhart, 917 Tenney Building, Madison (ex officio)

COMMITTEE OF HOUSE OF DELEGATES

Special Committee on Nursing Education

Dr. W. A. Munn, chairman, 19 South Main Street, Janesville

Dr. H. M. Stang, 314 East Grand Avenue, Eau Claire

Dr. Burton Clark, 11 Algoma Boulevard, Oshkosh

Dr. F. A. Stratton, 324 East Wisconsin Avenue, Milwaukee

Dr. J. W. Gale, 1300 University Avenue, Madison

OFFICERS OF SECTIONS

(Elected annually by section members)

Eye, Ear, Nose and Throat

Dr. F. A. Davis, chairman, 224 West Washington Avenue, Madison

Dr. H. B. Beeson, vice-chairman, 423 Main Street, Racine

Dr. R. O. Ebert, secretary-treasurer, 104 Main Street, Oshkosh

Orthopedics

Dr. H. C. Schumm, president, 425 East Wisconsin Avenue, Milwaukee

Dr. W. P. Blount, secretary–treasurer, 324 East Wisconsin Avenue, Milwaukee

Radiology

Dr. T. J. Pfeffer, chairman, 1526 Grand Avenue, Racine

Dr. F. C. Christensen, vice-chairman, 208 Eighth Street, Racine

Dr. R. F. Wilson, secretary-treasurer, 431 Olympian Boulevard, Beloit

A. M. A. FELLOWSHIP

The difference between membership and fellowship in the American Medical Association is set forth below:

A member of a county medical society automatically becomes a member of the State Medical Society and the American Medical Association, but not a Fellow of the American Medical Association. To become a Fellow of the American Medical Association, he must make special application and pay to the Association the annual dues of $8 (which are credited to a year's subscription to The Journal of the American Medical Association).

Many physicians who pay $8 a year for their subscription to The Journal of the American Medical Association are not Fellows only because they have never applied for Fellowship. Only Fellows may register or take part in the annual meeting of the American Medical Association which, in 1941, will be held in Cleveland, June 2–6.

AMERICAN MEDICAL ASSOCIATION

535 North Dearborn Street, Chicago

APPLICATION FOR FELLOWSHIP

_____, 19____

I hereby make application for Fellowship in the American Medical Association and subscribe for The Journal for one year from date. I am a member in good standing of the _____ County Medical Society, a component branch of the _____ State Medical Association.

N. B.—Eight dollars is deposited with this application. Should I be granted the Fellowship applied for, this fee is to be credited to my subscription for *The Journal*. The Fellowship for which this application is made is to be subject to the Constitution and By-Laws of the American Medical Association.

Signed _____

Name in Full

Street _____ County _____

City _____ State _____

Members, State Medical Society of Wisconsin

Abbotsford:
Shields, G. G.

Ableman:
McGonigle, B. E.

Abrams:
Faulds, R. C.

Adams:
Harris, A. J.
Shapiro, Harry

Adell:
Bemis, I. M.
Naylen, F. J.

Albany:
Bongiorno, F. J.

Algoma:
Bertram, B. J.
Foshion, H. V.
Witcpalek, W. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Almena:
Arneson, Thomas

Amery:
Cornwall, W. B.
Ford, K. K.
Kremser, V. C.
Waterman, I. W.

Amherst:
Dorsch, J. F.

Antigo:
Bloor, E. G.
Curran, W. P.
Donohue, M. J.
Dorzeski, E. F.
Flatley, M. A.
Lambert, J. W.
McKenna, E. A.
Moore, G. E.
Portman, R. J.
Zellmer, C. E.

Appleton:
Archer, W. E.
Benton, J. L.
Bolton, E. L.
Brooks, E. H.
Carlson, G. W.
Dehne, W. O.
Frawley, W. J.
Gallaher, D. M.
Giffin, W. S.
Gloss, A. J.
Harrington, Wm. J.
Hegner, G. T.
Huberty, F. J.
Konz, S. A.
Krueger, E. N.
Landis, R. V.
MacLaren, J. B.
Marshall, V. F.
Marshall, W. S.
McBain, L. B.
McCarty, R. T.
McGrath, E. F.
Mielke, E. F.
Mills, N. P.
Neidhold, C. D.
Pardee, C. A.
Rankin, F. J.
Rector, A. E.
Reeve, J. S.
Ritchie, G. A.
Swanton, M. E.
Troxel, J. C.
Young, J. J.
Zeiss, E. J.

Arcadia:
Comstock, Elizabeth
Dockendorff, B. C.
Skroch, J. P.
Weber, F. T.

Argyle:
Eurit, D. H.
Williams, W. B.

Ashland:
Andrus, A. D.
Butler, Albert
Dodd, J. M., Sr.
Grand, C. A.
Grigsby, R. O.
Kamm, A. X.
Lamal, A. H.
Meyer, M. W.
Prentice, J. W.
Sandin, N. V.
Smiles, C. J.
Tucker, W. J.
Weeks, F. D.
Young, M. L.

Athens:
Bachhuber, H. M.
Frick, Lewis

Augusta:
Moland, O. G.
Prill, H. F.

Baldwin:
Kunny, B.
Swenson, G. B.

Bangor:
Ruppenthal, K. P.
Ward, M. W.

Baraboo:
Cahoon, Roger
Edwards, A. C.
Huth, M. F.
Irwin, H. J.
Moon, J. F.
Pearson, C. R.
Pope, C. B.
Tryon, F. E.
Vander Kamp, H.
Winslow, F. R.

Barron:
Post, C. C.
Ruethin, K. A.
Schlomovitz, H. H.
Smith, R. C.

Barton:
Driessel, S. J.

Bayfield:
Robertson, M. J.
Shumate, J. K.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Brumbaugh, E. V.
Clarke, T. C.
Corso, Xavier
Costello, W. H.
Hammond, A. W.
Hough, A. G.
Hoyer, A. A.
Hoyer, E. C.
Hoyer, G. H.
Kierzkowski, C. V.
O'Hora, C. M.
Roberts, Rob Roy
Rosenheimer, A. M.
Schoen, R. E.
Schoen, R. F.
Temkin, M. M.
Webb, E. P.
Welsch, J. M.

Belleville:
Donlin, W. F.

Beloit:
Allen, J. P.
Allen, W. J.
Baldwin, R. M.
Bane, Helen W.
Brinckerhoff, F. E.
Brown, E. B.
Burger, H. E.
Carney, C. M.
Crockett, W. W.
Crone, V. D.
Flarity, T. H.
Fosse, B.
Friend, L. J.
Friske, O. W.
Helm, H. M.
John, G. W.
Kasten, H. E.
Keithley, J. W.
Kishpaugh, H. W.
Mauermann, W. J.
Ottow, A. F.
Raube, H. A.
Ross, M. E.
Shearer, H. A.
Smith, C. E.
Springberg, J. C.
Thayer, R. A.
Vivian, R. S.
Wilson, R. F.

Benton:
Leitzell, P. W.

Berlin:
Koch, H. C.
Regan, D. M.
Seward, L. J.
Stone, G. C.
Stone, Mildred M.
Wiesender, A. J.

Big Bend:
Boldt, R. E.

Birchwood:
Ainsworth, H. H.

Birnamwood:
Damp, O. E.

Black Creek:
Laird, J. J.

Black Earth:
Marshall, F. S.

Black River Falls:
Krohn, Irwin
Krohn, Robert
Manz, K. F.

Blair:
Milchen, Carl
Richards, R. R.

Bloomer:
Clauson, C. T.
Hudek, D. F.
Sazama, J. J.

Bloomington:
Baldwin, F. H.
Glasier, M. B.
McLaughlin, H. J.

Blue Mounds:
Bancroft, H. V.

Blue River:
Randall, M. W.

Bonduel:
Terlinden, J. H.

Boscobel:
Hayman, C. S.
Spiegelberg, E. H.
Tuffley, F. S.

Bowler:
Rogers, V. S.

Brandon:
Hull, H. H.

Briggsville:
Boots, F. W.

Brodhead:
Mitchell, E. J.
Stuessy, M. W.

Brownsville:
Raymond, R. G.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Alcorn, M. W.
Bennett, J. F.
Feldmayer, J. E.
Granzeau, H. W.
Mastalir, L. O.

Cadott:
Zenner, C. E.

Cambria:
Ronneburger, E. O

Cambridge:
Amundson, K. K.
Bilstad, G. E.

Cameron:
Cronk, C. F.

Campbellsport:
Guenther, O. F.
Hoffmann, L. A.

Casco:
Fencil, Y. J.
Kerscher, E. J.

Cashton:
Cremer, C. H.
Mauel, N. M.

Cassville:
Rempe, A. C.

Cato:
Kelley, J. M.

Cedarburg:
Blanchard, P. B.
Hurth, O. J.
Hurth, O. W.
Katz, H. M.

Cedar Grove:
Van Altena, L. A.
Voskuil, A.

Centuria:
Noyes, G. B.

Chaseburg:
Remer, W. H.

Chetek:
Adams, R. W.

Chilton:
Goggins, J. W.
Knauf, N. J.
Minahan, J. J.

Chippewa Falls:
Daly, F. P.
Field, Merton
Hatleberg, C. N. B.
Henske, W. C.
Kelly, J. A.
McCarty, E. O.
McHugh, F. T.
Picotte, L. W.
Rodgers, R. S.
Sazama, F. B.
Somers, A. J.
Williams, S. E.

Clayton:
Campbell, L. A., Jr.

Clear Lake:
Campbell, L. A.
Nelson, A. N.

Cleveland:
Reinert, E. N.

Clinton:
Dodge, C. H.
Thomas, W. O.

Clintonville:
Auld, Irving
Braun, R. F.
Finney, W. H.
Miller, E. A.
Murphy, J. H.
Topp, C. A.

Cobb:
Brillman, C. R.

Cochrane:
Meili, E. A.

Colby:
Christofferson, H. H.
Schemmer, A. L.

Coleman:
Graner, L. H.

Colfax:
Cooper, C. A.
Felland, O. M.

Columbus:
Caldwell, H. M.
Cheli, C. F.
Frederick, A. J.
Mudroch, J. A.
Poser, E. M.
Poser, J. F.
Poser, R. O. F.

Coon Valley:
Solberg, A. A.

Cornell:
J. H. Foster

Crandon:
Ison, G. W.
Marsh, H. C.

* Complete up to December 2, 1940.

Cross Plains:
Froggatt, W. E. L.

Cuba City:
Bair, F. M.

Cudahy:
Fine, J. M.
Kash, S. H.
Krueger, B.
Lawler, E. M.
Partridge, C. D.
Smith, H. S.

Cumberland:
Lund, S. O.
Thompson, R. C.

Darien:
Levin, H. M.

Darlington:
McConnell, E. D.
McGreane, N. A.
Quinn, R. B.
Shockley, H. O.

Deerfield:
Ingwell, C. L.

Deer Park:
Dasler, T. W.

De Forest:
Carlton, E. P.

Delafield:
Barnes, H. T.
Olsen, L. C. J.

Delavan:
Bachelle, C. V.
Crowe, N. F.
Doughty, J. W.
Jacobson, T. L.
Kahn, E. M.
Kenney, H. J.
Wright, C. A.

Denmark:
Hager, F. J.
Michna, C. T.
Schilling, H. J.
Vosburgh, W. H.

De Pere:
Kersten, N. M.
Lenfestey, J. P.

De Soto:
Bolstad, H. A.

Dodgeville:
Buckner, H. M.
Hagerup, T. A.
Hamilton, W. P.
Morton, H. H.
Reese, William
Walker, H. M.

Dorchester:
Foley, F. P.

Dousman:
Schneider, Hans

Eagle:
Fitzgerald, J. J.

Eagle River:
Flannery, J. V.
Lindstrom, C. O.
McMurry, O. R.
Oldfield, R. A. A.

East Troy:
Meany, S. G.
O'Leary, T. J.

Eau Claire:
Anderson, F. G.
Baird, J. C.
Beebe, G. W.
Buckley, R. A.
Cook, F. S.
Culver, L. G.
Derge, H. F.
Dickelmann, L. E.
Falstad, C. H.
Federman, E. H.
Fuson, H. S.
Haag, A. F.
Hayes, E. P.
Henke, S. L.
Hertzog, A. J.
Hoyme, G.
Huston, H. C.
Ihle, C. M.
Johnson, Fred
Kinsman, F. C.
Kohl, Martha
LaBreck, F. A.
Lowe, J. W.
Manz, W. R.
Mason, E. L.
Midelfart, Peter
Mitchell, M. T.
Niver, E. O.
Paulson, W. O
Reynolds, G. S.
Russell, S. B.
Spelbring, P. G.
Stang, H. M.
Strand, R. C.
Tanner, J. W.
Werner, Nels
Werner, R. F.
Wishart, J. H.
Ziegler, J. E. B.

Eden:
Hardgrove, J. H.

Edgar:
Schulz, H. A.

Edgerton:
Morrison, W. W.
Shearer, A. T.
Shearer, F. E.
Sumner, W. C.

Elcho:
Dailey, P. J.

Eldorado:
Jackson, F. A.

Elkhorn:
Helmbrecht, M. G.
Rawlins, J. A.
Ridgway, E. T.
Sorenson, E. D.
Young, J. H.

Elm Grove:
Wheelihan, R. Y.

Elmwood:
Breed, A. L.

Elroy:
Vogel, C. A.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Guilfoyle, J. P.
Sorkin, S. S.

Fairchild:
Hendrickson, W. O.

Fall Creek:
Zboralske, F. F.

Fall River:
Hunt, F. O.

Fennimore:
Bailey, M. A.
Howell, E. C.
Marsden, T. H.

Fond du Lac:
Alexander, W. S.
Borsack, K. K.
Calvy, D. W.
Clark, P. J.
Dalrymple, R. R.
Devine, H. A.
Devine, J. C.
Finn, W. C.
Florin, A. C.
Folsom, W. H.
Gardner, L. C.
Gavin, S. E.
Helz, J. W.
Hutter, A. M.
Keenan, L. J.
Layton, O. M.
Leonard, C. W.
McCabe, P. G.
Meiklejohn, D. V.
Pawsat, E. H.
Rehorst, J. J.
Sharpe, H. R.
Sharpe, J. J.
Simon, L. J.
Smith, E. V.
Smith, E. V., Jr.
Theisen, S. A.
Twohig, D. J.
Twohig, H. E.
Twohig, J. E.
Waffle, R. L.
Waldschmidt, W. J.
Walters, D. N.
Werner, H. C.
Wier, J. S.
Wiley, F. S.
Yockey, J. C.

Footville:
Harvey, J. R.

Forest Junction:
Wollersheim, P. J.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Caswell, H. O.
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harris, J. J.
Venning, J. R.
Young, Will

Fountain City:
Skemp, F. C.

Fox Lake:
Elliott, E. S.

Franksville:
Dockery, G. A.

Frederic:
Andrews, W. C.
Arveson, R. G.
Johnson, K. F.

Fremont:
Arnoldussen, C. P.

Friendship:
Treadwell, G. F.

Galesville:
Alvarez, R. L.
Jegi, H. A.
Younker, F. T.

Gays Mills:
Ackerman, E. T.
Boyce, S. R.

Genesee Depot:
Jones, Griffith

Gillett:
Baldwin, L. H.
Berg, W. R.

Glenbeulah:
Hansen, John

Glenwood City:
McCusker, C. F.
McMahon, A. E.

Glidden:
Ansfield, F. J.

Goodman:
Kingsbury, C. H.

Grafton:
Balkwill, C. A.
Kalb, C. H.

Granton:
Rath, R. R.
Slater, R. H.
Wink, R. H.

Green Bay:
Atkinson, H. S.
Bartran, W. H.
Brusky, A. H.
Buchanan, R. C.
Burdon, T. S.
Burns, Robert
Carter, R. M.
Chloupek, C. J.
Clifford, P. M.
Colignon, J. C.
Comee, W. C.
Cowles, R. L.
Crikelair, F. L.
Denys, G. F.
Dockry, P. F.
Dupont, A. J.
Filek, Allan
Ford, J. L.
Ford, W. W.
Fuller, M. H.
Gosin, D. F.
Gosin, F. J.
Hagerty, W. T.
Halloin, J. E.
Heitzman, H. H.
Hendrickson, H.
Icks, Karl
Jordan, E. M.
Kelly, W. W.
Killins, W. A.
Kispert, R. W.
Knox, E. S.
Kuehl, F. O.
Leaper, W. E.
Levitas, I. E.
McCarey, A. J.
McNevins, E. S.
Milson, Louis
Minahan, P. R.
Mokrohajsky, S. M.
Nadeau, E. G.
O'Brien, E. J.
Olmsted, A. O.
Quigley, L. D.
Robb, J. J.
Saunders, O. W.
Schmidt, E. S.
Shinners, G. M.
Stauff, G. R.
Stiennon, O. A.
Tippet, W. P.
Troup, R. L.
Troup, W. J.
Vieaux, J. W.
Williamson, C. S.

Green Lake:
Baldwin, G. E.
Kelly, J. A.

Greenleaf:
Titel, E. A.

Greenwood:
Olson, Wm. A.
Overman, M. V.

Gresham:
Litzen, F. L.

Hales Corners:
Pierce, D. F.
Wolf, R. C.

Hammond:
Olson, C. A.

Hartford:
Hoffmann, J. G.
Lehmann, F. W.
Loughlin, T. F.
Monroe, M. E.
Sachse, F. W.

Hartland:
Brewer, G. W.

Hawthorne:
Lookanoff, V. A.

Hayward:
Adams, Sylba
Callaghan, D. H.
Dufour, E. H.
Krueger, E. R.
Wesche, G. E.

Hazel Green:
Fillbach, H. E.
Strauch, C. B.

Highland:
Erickson, M. T.

Hilbert:
Winkler, R. J.

Hillsboro:
Hansberry, P. H.
MacKechnie, R. S.
Rouse, J. J.

Hixton:
Petzke, E. A.

Hollandale:
Marshall, S. B.

Holmen:
Hanson, L. E.

Horicon:
Bloom, C. S.
Karsten, J. H.

Hortonville:
Adrians, W. A.
Towne, W. H.

Howards Grove:
Kolb, F. K.

Hudson:
Livingstone, J. W.
Newton, J. E.

Hurley:
Krumpelbeck, A. C.

Hustisford:
Panetti, P. A.

Independence:
Peterson, C. F.
Peterson, D. R.
Waiske, B. R.

Iola:
Wilker, W. F.

Iron Ridge:
Quackenbush, E. C.

Iron River:
Johnson, F. G.

Jackson:
Froede, H. E.

Janesville:
Anderson, H. A.
Bartels, G. W.
Baumgartner, M. M.
Binnewies, F. C.
Clark, W. T.
Cunningham, M. A.
Danforth, H. C.
Farnsworth, F. B.
Farnsworth, R. W.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Hartman, E. C.
Hartman, R. C.
Hatfield, M. E.
Johnson, W. L.
Keiley, J. F.
Klein, T. W.
Koch, V. W.
Kuegle, F. H.
McGuire, W. H.
Metcalf, G. S.
Munn, W. A.
Nuzum, T. O.
Nuzum, T. W.
Overton, O. V.
Pember, A. H.
Snodgrass, T. J.
Thomas, G. L.
VanKirk, F. W.
Waufle, G. C.
Welch, F. B.

Jefferson:
Brewer, J. C.
Busse, A. A.
Garding, C. J.
Robinson, A. H.

Johnson Creek:
Wendt, F. A.

Junction City:
Reis, G. W.

Juneau:
Heath, H. J.
Hebenstreit, A. J.

Kaukauna:
Bachhuber, A. E. Jr.
Bachhuber, A. M.
Boyd, C. D.
Boyd, G. L.
Flanagan, G. J.
Hogan, John
Leigh, Albert

Kenosha:
Andre, E. F.
Ashley, T. W.
Bennett, W. H.
Binnie, Helen A.
Bowing, I. E.
Cleary, J. H.
Creswell, C. M.
Curtiss, F. D.
Davin, C. C.
DeFazio, S. F.
Gephart, C. H.
Graves, J. P.
Hill, B. S.
Kleinpell, W. C.
Lipman, W. H.
Lokvam, L. H.
Mayfield, A. L.
McCarthy, G. W.
Murphy, S. W.
Pechous, C. E.
Perkins, C. H.
Pifer, P. E.
Pirsch, M. V.
Randall, A. J.
Rauch, A. M.
Rauen, L. M.
Richards, C. G.
Ripley, H. M.
Ruffolo, A. F.
Schiapik, A.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Sokow, Theodore
Stewart, W. C.
Swarthout, E. F.
Ulrich, C. F.
Windesheim, G.
Wolf, Herman

Keshena:
Rivard, R. R.

Kewaskum:
Edwards, R. G.
Hausmann, N. E.

Kewaunee:
Dana, D. B.
Witcpalek, E. W.
Wochos, F. J.
Wochos, W. M.

Kiel:
Knauf, F. P.
Nauth, D. F.
O'Donnell, S. P.

Kimberly:
Maes, C. G.

Kohler:
Cottingham, M. D.
Gascoigne, C. C.

La Crosse:
Anderson, N. P.
Bannen, W. E.
Bayley, W. E.
Bohn, M. H.
Callahan, J. L.
Carlsson, E. S.
Daley, D. M.
Douglas, F. A.
Eagan, R. L.
Egan, G. J.
Eidam, L. W.
Flynn, R. E.
Fox, J. C.
Gallagher, E. E.
Gallagher, F. J.
Garrett-Bangsberg, S.
Gatterdam, P. C.
Gray, R. H.
Gundersen, A. H.
Gundersen, G.
Gundersen, S. B.
Harman, J. C.
Heraty, J. E.
Houck, Mary Piper
Johnston, Russell
Jones, W. J.
Lueck, G. W.
Malin, G. W.
Mast, B. W.
McGarty, M. A.
McLoone, J. E.
Montgomery, S. A.
Moran, C. J.
Reay, G. D.
Reay, G. R.
Rosholt, J. A.
Schneeberger, E. J.
Simones, J. J.
Sivertson, M.
Skemp, A. A.
Skemp, G. E.
Smith, D. S.
Swarthout, Edyth C.
Townsend, E. H.
Walters, P. T.
Wolf, F. H.
Wolf, H. E.

Ladysmith:
Lundmark, L. M.
O'Connor, W. F.
Pagel, H. F.
Smith, Woodruff

La Farge:
Goilin, F. F.

Lake Geneva:
Brady, C. J.
Donath, L. H.
Halsey, R. C.
Hudson, E. D.
Jeffers, Dean
MacDonald, W. H.

Lake Mills:
Eck, G. E.
Leicht, Phillip
Peterson, M. G.
Schoenecker, E. A.

Lancaster:
Carey, H. W.
Fowler, J. H.
Glynn, J. D.
Godfrey, R. C.
Houghton, E. M.

Laona:
Ovitz, E. G.

Larsen:
Henrichsen, J. A.

LaValle:
Booher, J. A.

Lena:
Rose, J. F.

Little Chute:
Curtin, D. W.
Doyle, J. H.

Lodi:
Irwin, G. H.

Loganville:
Jewell, E. L.

Lone Rock:
Reynolds, Bertha

Loyal:
Hable, A. L.

Luck:
Peterson, S. C.

Madison:
Aageson, C. W.
Atwood, David
Bleckwenn, W. J.
Bohorfoush, J. G.
Boner, A. J.
Bowman, F. F.
Briggs, S. J.
Brindley, B. I.
Britton, D. M.
Bryan, A. W.
Buerki, R. C.
Burke, C. F.
Burke, Mead
Burns, R. E.
Calvert, Charlotte
Campbell, R. E.
Carns, Marie L.
Carter, H. M.
Chorlog, J. K.
Cole, L. R.
Coluccy, M. J. J.
Cooksey, R. T.
Cooper, G. A.
Davis, F. A.
Dean, F. K.
Dean, J. C.
Dean, J. P.
Dimond, W. B.
Dollard, J. E.
Duehr, P. A.
Ellis, I. G.
Evans, J. S.
Ewell, G. H.
Fauerbach, L.
Fosmark, C. A.
Foster, Ruth C.
Gale, J. W.
Gallagher, J. T.
Ganser, W. J.
Gearhart, R. S.
Geist, F. D.
Gonce, J. E., Jr.
Greeley, H. P.
Greene, H. L.
Grimstad, Frances H.
Grumke, E. H.
Guilford, H. M.
Halperin, P. H.
Harper, C. A.
Harper, C. S.
Harris, J. W.
Hill, N. A.
Holmgren, L. E.
Hunter, Amy Louise
Hurlbut, J. A.
Hyslop, V. B.
Jackson, A. S.
Jackson, J. A.
Jacobson, F. C.
Johnson, H. C.
Juster, E. M.
Kay, H. M.
Krehl, W. H.
Kundert, F. W.
Lacke, C. L.
Lee, J. H.
Lemmer, K. E.
Leonard, T. A.
Lindsay, W. T.
Littig, L. V.
Long, Leonard
Lorenz, W. F.
Macht, A. J.
Malec, J. P.
Maloof, G. J.
Marsden, W. H.
Marsh, H. E.
Masten, M. G.
McCormick, D. W.
McCormick, S. A.
McDonough, K. B.
McGary, Lester
McIntosh, R. L.
Meanwell, W. E.
Meister, F. O.
Meyer, O. O.
Middleton, W. S.
Mideifart, C. F.
Montgomery, R. C.
Mowry, W. A.
Neff, E. E.
Nelson, E. R.
Nelson, O. O.
Nesbit, M. E.
Nesbit, W. M.
Neupert, C. N.
Newman, J. R.
Paul, L. W.
Pessin, Joseph
Pessin, S. B.
Pohle, E. A.
Puestow, K. L.
Quisling, A. A.
Quisling, G. D.
Quisling, R. A.
Quisling, Sverre
Reese, H. H.
Reineking, W. C.
Reznichek, C. G.
Robbins, J. H.
Rosenberg, C. F.
Schmidt, E. R.
Schneiders, E. F.
Schubert, C. K.
Schwittay, Addie M.
Seaman, G. E.
Seevers, M. H.
Sevringhaus, E. L.
Shapiro, H. H.
Sinaiko, A. A.
Sisk, I. R.
Sisk, J. N.
Sprague, J. T.
Sprague, L. V.
Stebbins, G. G.
Stebbins, W. W.
Stehr, A. C.
Stiehm, R. H.
Stovall, W. D.
Sullivan, A. G.
Sullivan, E. S.
Supernaw, J. S.
Taylor, F. B.
Tenney, H. K.
Thomas, N. G.
Thornton, M. J.
Tormey, A. R.
Tormey, T. W.
Tormey, T. W., Jr.
Trautmann, M.
Van Riper, H. E.
Vingom, C. O.
Virgin, H. W.
Washburne, A. C.
Waters, R. M.
Wear, J. B.
Weiland, H. P.
Weismiller, L. L.
Weike, E. G.
Wells, May R.
Werrell, W. A.
Weston, F. L.
Wheeler, R. M.
Williams, D. L.
Winn, H. N.
Wirig, M. H.
Wirka, H. W.

Manawa:
Irvine, R. K.
Irvine, W. J.

Manitowoc:
Andrews, M. P.
Belson, H. J.
Bonner, N. A.
Donohue, W. E.
Erdmann, N. C.
Gregory, L. W.
Hammond, F. W.
Hammond, R. W.
Hoffman, G. M.

Howe, G. E.
MacCollum, C. L.
Meany, J. E.
Rauch, W. A.
Rees, T. H.
Scherping, W. H.
Schneck, Nathan
Sobush, L. D.
Steckbauer, J. W.
Strong, R. G.
Stueck, A. F.
Teltgen, Arthur
Teltgen, T. A.
Turgasen, F. E.
Wall, C. E.
Yost, R. G.

Marathon:
Kampine, C. E.

Maribel:
May, J. H.

Marinette:
Barnes, Haidor
Bird, M. D.
Boren, C. H.
Boren, J. W.
Duer, G. R.
Jorgenson, H. L.
May, J. V.
Nadeau, A. T.
Pinegar, K. G.
Schroeder, H. F.
Shaw, R. W.
Zeratsky, J. D.

Marion:
Mulvaney, F. M.
Van Schaick, R. E.

Markesan:
Sinaiko, E. S.

Marshfield:
Baldwin, R. S.
Boeckman, F. A.
Copps, L. A.
Doege, K. H.
Doege, P. F.
Epstein, S. E.
Hipke, Wm.
Mason, R. W.
McCormick, G. L.
McGinn, E. J.
Millard, A. L.
Potter, R. P.
Sexton, W. G.
Talbot, J. R.
Vedder, C. A.
Vedder, H. A.
Vedder, J. B.
Vedder, J. S.

Mattoon:
Partridge, O. F.

Mauston:
Day, L. C.
Hess, J. S.
Kaufman, A. R.
Puttler, O. L.

Mayville:
Bachhuber, F. G.
Parish, G. A.

Mazomanie:
Schultz, I.

Medford:
Eivis, E. B.
Norton, D. M.
Nystrum, L. E.
Nystrum, R. C.

Mellen:
Lockhart, C. W.

Melrose:
Lavine, I. H.

Menasha:
Forkin, G. E.
Jensen, F. G.
Jensen, R. A.
O'Brien, P. T.
Pratt, G. N., Jr.
Shemanski, L. S.
Skibba, J. P.

Mendota:
Green, M. K.
Sauthoff, August
Urben, W. J.

Menomonee Falls:
Burkhardt, E. W.
Domann, W. G.
Hoyt, G. E.
Schloemer, A. J.

Menomonie:
Buckley, C. H.
Butler, F. E.
Grannis, I. V.
Halgren, J. A.
Long, D. T.
Lumsden, Wm.
Quilling, P. A.
Steves, B. J.
Steves, R. J.

Mercer:
Kremers, A.

Merrill:
Austria, W. F.
Bayer, L. J.
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Hinckley, H. G.
Kelley, F. H.
Lando, D. H.
Lane, F. C.
Morris, K. A.
Ravn, Bjarne
Ravn, E. O.

Middleton:
Allen, C. F.
Stricker, M. F.

Milltown:
Bergstrom, L. V.
Nicholson, J. D.
Rechlitz, E. T.

Milton:
Crosley, G. E.
Davis, M. D.

Milton Junction:
Vogel, T. L.

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Ackerman, J. S.
Ackermann, Wm.
Adamkiewicz, J. J.
Allebach, H. K. B.
Allen, L. L.
Ansfield, D. J.
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Armbruster, J. L.
Aszman, P. E.
Augur, Alexander
Ausman, D. C.
Ausman, H. R.
Aussendorf, C. F.
Aylward, T. J.
Bach, E. C.
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Baker, V. L.
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Bardenwerper, H. E.
Barnes, J. S.
Barrock, J. J.
Barta, E. F.
Baugh, C. W.
Baum, E. L.
Baumann, A. J.
Baumgart, C. H.
Becker, C. J.
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Beckman, Harry
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Beiknap, E. L.
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Bender, B. I.
Bensman, L. L.
Benton, R. W.
Bentzien, E. W.
Bercey, J. E.
Bergen, R. D.
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Beyer, C. H.
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Borman, M. C.
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Boxer, L. M.
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Cahana, Stephen
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Cushing, Eleänore
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Doerr, August
Dorpat, Louis
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Drew, F. E.
Drexel, Arnold
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Dunker, G. O.
Dunn, C. F.
Durner, U. J.
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End, E. M.
Enright, J. A.
Enzer, Norbert
Epperson, P. S.
Epstein, Ely
Ernst, G. R.
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Everts, E. L.
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Falk, V. S.
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Fein, N. N.
Feld, S. M.
Feldt, R. H.
Feliman, G. H.
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Fetherston, J. P.
Fidler, Charles
Fifrick, L. L.
Fisher, L. M.
Fitzgerald, G. F.
Fitzgerald, R. E.
Fitzgibbon, Wm.
Fletcher, E. A.
Foerster, H. R.
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Foley, L. J.
Fons, J. W.
Ford, W. B.
Fortier, C. A. H.
Fox, G. W.
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Frawley, D. D.
Frey, P. G.
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Fromm, A. H.
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Gabor, M. E.
Galasinski, R. E.
Garens, R. W.
Garland, J. G.
Garvey, J. L.
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Geiger, Sara G.
Gendlin, N. A.
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Gilmer, L. T.
Gingrass, R. P.
Gilsch, W. P.
Goldberg, Nathan
Goodman, J. N.
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Gorder, A. C.
Gordon, J. S.
Grab, J. A.
Gramling, E. H.
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Gray, A. W.
Greenberg, A. I.
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Grob, A. R. F.
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Guepe, J. W.
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Habeck, E. A. W.
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Hankwitz, A. W.
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Hansen, A. C.
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Hardy, C. F.
Hargarten, L. J.
Harper, C. W.
Harrington, E. T.
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Heeb, H. J.
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Helfetz, E. C.

Hell, J. V.
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Hollenbeck, S. W.
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Huber, H. H.
Hughes, J. R.
Hume, W. W.
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Irwin, Robert
Jackson, Edward
Jacobson, E. B.
James, L. J.
Jefferson, R. A.
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Joseph, W. A.
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Jurss, C. D.
Kahn, Joseph
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Kilbourne, B. C.
Kilian, A. D.
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Kinsey, J. L.
Kissinger, C. A.
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Klein, J. T.
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Klumb, M. G.
Knudson, A. H.
Koch, M. J.
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Koehler, J. P.
Kohn, S. E.
Kovacs, Arthur
Kozina, F. J.
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Kretchmar, L. H.
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Kretlow, F. A.
Kristjanson, H. T.
Kritter, F. J.
Kriz, G. A.
Kriz-Hettwer, Rose
Krumbiegel, E. R.
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Krzysko, S. L.
Kuhn, H. J.
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Kult, A. S.
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Kusterman, A. F.
Lademan, O. E.
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Lahmann, A. H.
Lambeck, F. J.
Lando, D. H., Jr.
Lang, V. F.
Langjahr, A. R.
Lawhorn, C. C.
LeCron, W. L.
Lee, P. A.
Leitch, G. W.
Lettenberger, J.
Levine, Abram
Lewis, Marian
Lieberman, Benj.
Liefert, W. C.
Light, George
Lillie, O. R.
Lobedan, E. T.
Long, C. W.
Lotz, Oscar
Loughlin, D. M.
Love, I. B.
Lungmus, B. A.
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MacInnis, F. E.
MacKedon, W. L.
MacKenzie, J. A.
Mackoy, F. W.
MacRae, M. F.
Madison, F. W.
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Maercklein, O. W.
Malnekoff, B. J.
Malone, J. Y.
Mann, R. W.
Margoles, F. C.
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Martens, E. W.
Martin, H. G.
Martineau, E. L.
Mason, E. W.
Matthews, J. B.
McBeath, N. E.
McCabe, John
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McCann, Edith
McCormack, M. T.
McCormick, F. X.
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McDonald, C. F.
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McGovern, J. J.
McKillip, W. J.
McKittrick, N. W.
McMahon, F. B.
McMahon, H. O.
McNary, J. F.
McNaughton, W. T.
Megna, J. A.
Megna, Salvatore
Mehigan, D. D.
Mellencamp, F. J.
Meloy, G. E.
Mendeloff, H.
Mensing, E. H.
Merten, A. N. E.
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Mitchell, S. R.
Mock, F. C.
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Monaghan, L. J.
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Mueller, G. F. C.
Muenzner, R. J.
Mulsow, J. E.
Munkwitz, F. H.
Murphy, F. D.
Murphy, J. A.
Murphy, W. J.
Natenshon, A. L.
Nebel, Harold
Neilson, G. W.
Nelson, J. D.
Nelson, W. V.
Neville, Mary
Newberry, C. L.
Newcomb, C. J.
Nichols, C. H.
Niland, P. J.
Nolte, L. G.
Northey, T. M.
Nugent, A. C.
Oakland, H. G.
Oberbreckling P. E.
O'Hara, J. J.
O'Leary, E. B.
O'Leary, Mary J.
Olsen, A. H.
Olsen, Maurice
Olson, H. J.
O'Malley, T. S.
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O'Neill, E. J.
Oswald, Frederick
Ovitt, D. W.
Owen, J. D.
Ozonoff, J. B.
Pallasch, F. J.
Panetti, E. J.
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Park, C. F.
Patek, A. J.
Paulbeck, T. M.
Pegram, J. W.
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Peterman, M. G.
Peters, L. M.
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Pfeffer, E. N.
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Piaskoski, R. G.
Pink, J. J.
Pleyte, A. A.
Pohle, H. W.
Polacheck, W. S.
Pollack, S. K.
Popp, Albert
Powers, H. W.
Presti, A. A.
Prudowsky, H. H.
Pugh, G. J.
Purtell, P. J.
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Quick, A. J.
Quick, E. W.
Ragan, W. F.
Raine, Forrester
Randolph, T. G.
Rank, R. T.
Rastetter, J. W.
Raymond, A. J.
Reifenrath, I. B.
Reinke, C. C.
Rettig, E. H.
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Rice, E. M.
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Rife, C. S.
Rikkers, D. F.
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Roby H. S.
Rock, J. N.
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Ruschhaupt, L. F.
Russell, R. J. M.
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Sadoff, H. B.
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Sargent, J. C.
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Scholter, E. A. W.
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Shutkin, Michael
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Usow, J. M.
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Weller, R. R.
Wenn, J. F.
Wenstrand, D. E. W.
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Westhofen, R. C.
Wetzler, S. H.
Whalen, G. E.
Wieder, L. M.
Wiese, M. E. J.
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Zmyslony, W. P.
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Mineral Point:
Ludden, H. D.

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Torpy, T. G.

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Sharp, D. S.

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Mount Horeb:
Forman, Judson
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Voellings, W. J.

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Kelm, G. J.

Neenah:
Anderson, G. R.
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Beglinger, H. F.
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Nekoosa:
Backus, O. A.
Pomainville, G. J.
Pomainville, H. G.

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Weber, H. F.

New Franken:
Looze, J. A.

New Glarus:
Francois, S. J. A.
Hicks, E. V.
McQuillin, E. D.

New Holstein:
Engel, A. C.
Krohn, H. C.

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Starnes, Brand

New London:
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Monsted, J. W.
Pfelfer, F. J.
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Armstrong, J. H.
Drury, E. M.
Epley, O. H.

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Allen, J. S.

Oconomowoc:
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Hassall, J. C.
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Loughnan, A. J.
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Wilkinson, D. C.
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Rogers, R. J.
Slaney, A. F.
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Goggins, R. J.
Krahn, G. W.
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Bitter, R. H.
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Peterson, L. W.
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Transactions 1940 Sessions, House of Delegates, State Medical Society of Wisconsin, Milwaukee

TUESDAY SESSION

The first session of the House of Delegates was called to order by the Speaker, Dr. J. Newton Sisk, Madison, in the Banquet Room of the Hotel Schroeder, Milwaukee, at 6:50 p. m., Tuesday, September 17, 1940.

Dr. A. G. Hough, Beaver Dam, presented the report of the Committee on Credentials, and upon his motion, seconded by Dr. C. A. Armstrong, Prairie du Chien, the report was adopted and a quorum declared present.

At the suggestion of the Council, the Secretary suggested that the House go into executive session to permit of fullest and freest expression, and remain in executive session until the adjournment sine die on Thursday. Such motion was made by Dr. Charles Fidler, Milwaukee, seconded by Dr. C. J. Weber, Sheboygan, and carried.

After a brief discussion by the Speaker concerning the advantages of free and open discussion on all subjects, he announced the appointment of the following reference committees: Credentials—Dr. A. R. Tormey, Madison, chairman; Dr. A. G. Hough, Beaver Dam; Dr. W. S. Waite, Watertown. Reports of Officers and Standing Committees—Dr. Irwin Schulz, Milwaukee, chairman; Dr. Hugh Caldwell, Columbus; Dr. D. J. Twohig, Fond du Lac; Dr. S. L. Henke, Eau Claire; Dr. G. C. Schulte, Kenosha. Resolutions—Dr. W. D. Stovall, Madison, chairman; Dr. Charles Fidler, Milwaukee; Dr. L. O. Simenstad, Osceola; Dr. A. A. Cantwell, Shawano; Dr. P. R. Minahan, Green Bay. Constitution and By-Laws—Dr. J. W. Boren, Marinette, chairman; Dr. E. H. Spiegelberg, Boscobel; Dr. W. M. Trowbridge, Viroqua; Dr. E. D. Sorenson, Elkhorn. Report of the Council—Dr. K. H. Doege, Marshfield, chairman; Dr. W. A. Munn, Janesville; Dr. J. C. Griffith, Milwaukee; Dr. J. W. Prentice, Ashland; Dr. R. M. Kurten, Racine.

Upon motion of Dr. J. F. Smith, Wausau, seconded by Dr. L. O. Simenstad, Osceola, the minutes of the 1939 sessions of the House of Delegates were approved.

The Speaker announced that to conserve time, reports, which had been published in the August issue of the Journal and had been sent to officers, would be referred direct to reference committees without first being read on the floor of the House, but that there were seven supplementary reports to be presented. The Speaker then introduced to the members the President of the State Medical Society, Dr. R. G. Arveson, Frederic.

Address of President R. G. Arveson

President Arveson: Mr. Speaker and Gentlemen of the House:

Fifteen to twenty years ago the State Medical Society of Wisconsin enjoyed a comfortable existence. It collected annual dues, made no great effort to enroll every possible medical man in good standing, met once a year in annual meeting, listened to some medical papers, had a good time generally, and called it a day.

Today, this organization is one of the best medical societies in the United States. Being an intimate part of society, it found itself, especially in the past eight years, confronted with the very radical change in government and public thought. We who lived before 1930 believed in the proposition that governments exist by the support of the people, and in the short space of eight years we have lived to see a new philosophy, that of the government supporting the people.

Various handicaps, obstructions, and hurdles have been placed around business and trade, and yet trade is perhaps the oldest occupation of man. The cornucopia has been lightly held by those presently in power, and out of it has tumbled old-age pensions, relief (direct and indirect), social security, grants of all kinds, medical aid, etc. I mention these merely to illustrate and not to condemn.

We have lived to see the day when the American Medical Association—and every one of you sitting here is of that Association—finds itself before a United States court defending itself from the charge of being a monopoly and a trade. Still, every one of you knows that the American Medical Association is a loosely organized body, composed of the many state medical societies which, in turn, are made up of county medical societies. Some physicians, even today, do not realize they are part and parcel of the American Medical Association. As a united and organized profession, which brought forth a code of ethics, promoted the public health, and, above all, advanced the science of medicine, we did not expect to be publicly censured for what we thought was our duty. However, each and every one of you knows what has come about in the past several years in regard to the attitude of the government and the so-called liberal satellites buzzing around it.

Out of this pressure, however, we have arisen stronger than ever, and even more resolved to maintain the independent practice of medicine. It has, in a way, been good for us; it has made us loyal, it has made us a cohesive body, it has made us strong. In the past few years this Society has shown an active disposition to not being shoved around at will, as it

did in the past. It refuses to allow unfriendly legislators to dictate to it and lower the quality and efficiency of medicine. Over the United States this profession has loomed large; in fact, it has stood head and shoulder above others, such as business, industry, and other professions, in maintaining its independence of thought and action, while they bowed down, in most instances, to government threats and dictation.

Through it all we have maintained as our watchword the "Individuality of the Practice of Medicine." The profession has refused to agree with the new philosophy of regimentation and has refused to give over lock, stock, and barrel to a government or anyone else its collective results of centuries of study, experiment and experience. Medicine has accumulated, over a long experience, certain understandings of people and recognizes them only as human beings—human beings with moods, joys, and faults —and it does not propose then to hand over its fate to a small group of self-appointed reformers and idealists without a fight. It has observed with regret, in lands across the sea, that our colleagues have been disorganized by their governments, that science has in great measure been stifled, and that the physician and the public have been tethered out on a lot to do the bidding of those with strange ideologies who are in power.

Therefore, let me say to you again that this Society is standing upon its feet—a strong, scientific, public-minded organization—and it intends to stay so. It represents medicine in Wisconsin, it represents a united front, and almost 2,500 men and women are its members. The progress it has made has been due to the sweat and, in some instances, almost the blood, of its officers, its painstaking Council, its intelligent House of Delegates, its hard-working committees, committees which gave unstintingly of their time, its county presidents and secretaries, to say nothing of the rank and file of medical men in this state who are willing to drop any work at once to do something for the Society when requested. The work of your President has not always been a bed of roses, but he feels fully repaid in the loyal support he has received from each and every member.

In closing this thought, let me remind you there are many and various types of medical organizations in this country, but the state medical society is basic and membership in it is required for entrance into them.

The Presidency.—The position of President is becoming more important each year. If a man were practicing alone and had an active practice, I do not exactly see how he could hold the position without some injustice either to his patients or to his position. There is much time spent in travel, talking to county societies and councilor districts, to say nothing of the various committee meetings and addresses to lay groups. Much correspondence is necessary, as well as hours of reading endless reports and statistics until one is weary.

Then there is the President's Page. Dr. Rector told me there was nothing to it; "but all men are liars," said David, and Dr. Rector afterward admitted he spoke hastily. The months have streamlined past me, and I found myself often with one page barely finished and the office calling for the next. But there is nothing to it, Dr. Sproule; you'll like it.

I hold today, as I did last year, that in the election of President the Nominating Committee should hold an open session and allow any member of the House to appear before it and suggest for the position anyone he may have in mind. He should state the qualifications, age, service to the Society, etc. All could not be elected, of course, but the committee could at least have several names brought before it for consideration.

The Council.—The Council is a fine body of men. It compares in a way to the Senate. Its duty is to carry on the affairs of the Society between the meetings of the House of Delegates. It is particularly charged with the responsibility of carrying out the wishes of the House. In all the meetings of the Council which I have attended, I have noticed it has religiously guarded this duty and has leaned backwards, in a way, to carry out these wishes, these and no more.

Due to the fact that these Councilors represent districts, and that they necessarily be men of vision, steadfastness, and intellect, it behooves every District to elect its most capable man.

From time to time there have been disagreements as to the proper method of selecting these men. At the present moment there is, in the order of business before this House, a resolution which would change the method of election, taking it from the floor of this House and putting it back in the district convention. I would caution the members of the House to weigh this very carefully in their minds. The caliber of men elected to the Council, in most instances, being as high as it is, it seems to me, at least, that great care should be exercised before any other method of selection is adopted.

There is very little the individual Councilor can do for his particular district, but, upon the other hand, he can do much for the State Society as a whole. I am mighty interested in whom they select from Milwaukee because he represents my interests, and I know the Milwaukee man is interested in the man whom we select in the Tenth District. If the individual member keeps in mind the fact that the Councilor represents the Society, the state as a whole, that he represents him as an individual, then he should be willing to have the best men elected at all times.

In any event, we have much work to do, work of importance, and whichever way you decide, let's establish a truce in the situation, or a "closed season," so to speak, for a number of years and not be plagued every session with the question of the method of holding the election of Councilors.

If the Councilor, upon the other hand, does not carry back to his people information vital to them

which he has learned at his meetings, then he should be a candidate for replacement.

I would be derelict, gentlemen, if I did not remind you of the untiring work of Dr. Gavin, chairman of the Council.

House of Delegates.—The House of Delegates, in a way, corresponds to the National House of Representatives. It is that branch in our government which represents the county society and the individual practitioner of medicine. There is no elected office in this Society which is so little understood by the profession at large. Some day, in my leisure, I am going to look up the names of the men who drew up our Constitution and By-laws. Whoever they were, they did a good job and did some long-time planning.

The delegate represents his people. Practice in different parts of the state is different, and he brings his colleague's problems before us for solution. He decides what moneys are necessary to operate the Society, what each shall contribute individually, what the Society shall spend, what projects and missions we shall embark upon. In fact, he is the Society.

No county society should elect a man as delegate just because he is the oldest member, or because he has the financial means to pay his expenses at the annual meeting. No county society should sit loosely assembled and have John Jones nominate Richard Smith as delegate just because he happens to be sitting next to him.

This is one of the really big jobs in our organization. What we need in the House are wide-awake, forward-looking men, whose hearts are in organized medicine, and who will take the time out to read something about the economics of medicine. If every state had that, nothing could stop us.

Many delegates come to the September meeting and have not read the order of business as printed in the Journal the month before. Upon the other hand, there are others who are well informed and, therefore, at times a handful of men run the meeting. Due to the battles we have gone through and those which we know will come, I speak plainly on this subject. Give me a House of Delegates which thoroughly understands the questions before it, and one which is aware of the medical trends, and I will show you a Society whose feet are anchored in the earth and whose outlook is the best.

The question of finances must be settled by the House, because it is its duty. I have been a member of the State Medical Society for a long time, and I have heard it whispered from time to time that the "King Makers" decide everything. I can truthfully say that this is not so. Upon the other hand, I know of innumerable men who serve in an official capacity and upon committees, who give freely of their time and their travel expenses, without collecting one cent from this Society for it.

Our postage, telephone, and telegraph expense, and other incidentals that go to make up the running of an office such as ours, is large. There are the bulletins, personal letters, and answers to inquiries. Our office force, after long service, has become very proficient and almost indispensible. We cannot make rapid changes in our force and expect the excellent service which we enjoy at this time.

All this activity requires money. Any new venture decided upon by you, such as experiments in sickness insurance or what-not, requires money. There is a small per cent of our members who object to this one item, and yet it was so ordered by the House in response to newspaper editorials condemning us for not attempting it. No one of you knows what is in store for us in the immediate future, but I suggest to you that the treasury be well stocked with ready funds, not an exorbitant amount but a reasonable amount, remembering at the same time that no funds can be spent unless by your consent and direction.

Quitting the subject, I will say that in no meeting which I have attended this year have I heard the question of finances debated, but all the societies in question thought we should have enough money successfully to combat movements deleterious to us.

The President, upon retiring, becomes a member of the House, and I appreciate the honor.

The Secretary.—In leaving this office I shall have one great regret, and that is losing the close association with George Crownhart. When I have grown weary and fallen asleep, he is still up and thinking.

I do not want to embarrass him here tonight, because I know of your high regard for him and of his devotion to medicine, but there is one thing I want to tell you which I have learned about him in the past two years, and that is he is always vitally and honestly interested in the welfare and the problems of every individual doctor in this Society. More pliable men might have become representative of the interests of small or special groups, but your Secretary has avoided this, and I am sure that in your inquiries of him you have received a personal and interested reply.

I do know that both he and his office have been overworked this past year, and I have urged him many times to let part of it go, and sit down and reflect upon some of the greater problems of medicine.

George Larson has been indefatigable, as have also been Hayden Smith, Lucia Stolp, Dorothy Cridland, and all the others.

In fact, our Madison office is in excellent shape.

The Treasurer.—The selection of Dr. Ira Sisk, a urologist, as Treasurer was a happy choice, especially so in view of the fact that all urologists are used to handling and talking money in large figures. He has attended all meetings of the Council and Executive Committee faithfully and keeps his finger continually upon our financial pulse.

The Auditing Committee, composed of Drs. Christofferson, Krahn, and Blumenthal, has examined the books of the Society and has found them accurate in all details.

The Future.—I would suggest to the House that it carefully and fully examine the question of a reregistration law in this state. I feel free to state that I believe almost any physician can come into this state, locate in any city or village without taking the State Board examination, and continue to practice for years without being disturbed. This likewise applied to chiropractors and osteopaths. Up to 1932 there were eighteen states which had passed a reregistration law; how many since I cannot say. Our sister states of Iowa and Minnesota have reregistration laws; Minnesota, with a $2 registration fee, has, in its treasury, $12,000, and employs a competent investigator who has weeded out all those not legally entitled to practice medicine.

Flagrant violations of medical practice, itinerant practitioners, those engaged in questionable practice, would all be brought before the scrutiny of the reregistration board and, in many cases, be denied the right to practice.

There were, up to 1932, the following states which had reregistration laws: California, Louisiana, Connecticut, Idaho, Iowa, New York, Pennsylvania, Nebraska, Oregon, Florida, Minnesota, Nevada, Wyoming, Colorado, North Dakota, Alaska, Georgia, and Texas. There may be others since that time. In this state nurses, dentists, and chiropractors are required to reregister each year, and if it applied to physicians you would be supplied from the State Board of Health with a printed booklet showing those eligible to practice medicine in this state, and probably also those licensed to practice in the other fields I have just mentioned.

Those of you who have waxed loud regarding the cultists, itinerants, constant violators of ethics, and violators of medical practice in general, should investigate this matter of reregistration carefully and fully. Visiting the annual meeting of the State of Minnesota, I found it was the one thing about which they were all enthusiastic. The Minnesota men tell me it is the one thing that has done more for medicine, for them, in the past twenty-five years than anything else. It merits your most earnest consideration.

I feel that the House should select a committee to study and report at the next session on the question of the selection of the Board of Medical Examiners. Realizing, as we do, that these men are the guardians of the portal of medical practice in this state, the Board should be composed of medical men interested in the high aims of medicine, and should not be the usual run of political appointees. Let's take the matter out of politics, if possible, and the committee so selected should make an exhaustive study of the selection of examining boards in the United States, and report back to us with proper recommendation.

Ignorance is rampant in the profession regarding the course and length of study required in medicine, osteopathy, chiropractic, and other cults. It is my suggestion, if favorably acted upon by this House, that the Secretary be instructed to send out to each member of the Society, and the Auxiliary as well, a printed statement which shall set forth the educational requirements and length of time necessary for completion of the course in medicine and the cults.

This is a thing which has been neglected too long by us. So armed, the profession and the Auxiliary will be able to discuss with, and educate, the public with regard to the relative merits of the qualifications of those engaged to treat the sick. Medicine cannot, in this day and age, expect to survive in fact, when it takes a "holier than thou" attitude and expects the public itself to ferret out the necessary information regarding the education of its healers. Very few in the profession offhand can state the qualifications or the course of study of those mentioned. Opportunity is often lost through delay.

The rank and file of physicians in this state find themselves today working harder for less financial return than at any time in our history. The fact that the span of life has greatly increased and that we find ourselves treating a large number of elderly people at greatly reduced prices, to say nothing of those upon relief, makes the close of the day a relief. After dinner the physician finds himself obliged to attend some medical meeting or staff meeting or one of a hundred other meetings. This is so because he is an intimate part of society and, further, his education and cultural background make him an ideal person to put upon some civic committee. Years ago he mingled freely in politics and helped in a great manner to shape the destiny of this state. Due, as I have stated, to increasing pressure, he finds himself out of politics and yet in this very field do we find those who oppose us and who would change the order of our existence. I would, therefore, advocate the doctor's return to the realm of politics.

Dr. C. A. Dawson, River Falls, has headed, for the past year, the Committee on Public Policy and has been untiring in his efforts to educate the physician to this very vital need. He is of the opinion that if the physician actively bestirred himself in his own behalf and influenced his friends, we could help in electing to public office those at least who would be willing to listen to our side of any question appertaining to public health or medical practice.

From my observation I feel that the profession in this state has taken a decided step forward in a new awakening in politics. Every man called upon this year for service in the presentation of medicine's attitude to aspiring candidates for the legislature must see to it that he performs the service quickly and well. There need be no hesitancy in this because, as I have stated before, the physician is an active part of society and he is always interested in legislation for the public good.

The greatest single need in Wisconsin medicine today is postgraduate instruction. I would like to see the general practitioner, who forms 85 per cent of the doctors in Wisconsin, kept up to date on 85

per cent of the diseases which he treats daily. The other 15 per cent probably should be taken care of by the specialist, and the specialist himself should work out further methods and means of actively cooperating with the general practitioner. With the detail man coming in this week and telling you that what he had to offer last week is old stuff, it behooves the profession to be on the march. Our people should be up and alert to the diagnosis of gastric ulcer, pneumonia, sinusitis, arthritis, the acute disease of the abdomen, to say nothing about heart disease and many others. Having talked with many medical men about the question of programs, I have noted the nostalgic yearning look in the eye of many of them, who feebly ventured to suggest they would like to hear a physiologist talk to them. Physiology is like a second piece of pie—it is denied them.

The Society in the past has made honest attempts to supply this instruction, but without any great degree of success. The universities have made some attempts, the county societies have invited medical men to appear before them, but all this has been more or less unorganized. The large medical centers, of course, supply their own needs, but I am talking about the state as a whole.

There are two medical schools in this state and both could do much, either singly or together, in making this necessary instruction a reality. I have been given to understand that the University of Wisconsin is about to embark upon such a course in the near future, and that provision will be made at the medical school for such study. This is welcome news and I am sure the offered service will be gratefully accepted.

I would suggest that this House of Delegates instruct its Committee on Scientific Work to cooperate with the University in this endeavor and also to formulate a scientific program for rural county societies, taking up one subject each month, that the men may become familiar with the up-to-date diagnosis and treatment of disease.

Wisconsin has lagged behind in this sort of work partly because of lack of funds, partly because of bad legislative pressure upon us, but mostly because we or the universities or some group of men failed to organize and direct the idea. There is no way, of which I know, that we can spend some of our money to better advantage.

In closing, may I again say to you that I thank you for the splendid cooperation during the year and the honor you have bestowed upon me in electing me to the presidency. I have accomplished nothing startling, but I feel flattered in that of the many suggestions I have offered, some have been put into operation.

In a few hours I shall turn over the office to Ralph P. Sproule, and I know, and I know that you know, it will be in good hands. Young and full of ambition, and with a very orderly mind, we expect great things of him, and I know that you and I wish him well.

The Speaker announced that this address of the President was referred to the Committee on Reports of Officers and Standing Committees.

Dr. R. P. Sproule, Milwaukee, President-Elect, was then introduced to the members by the Speaker, and addressed the House as follows:

Extracts From the Address of President-Elect Sproule

Mr. Speaker: During the past year I have attended the meetings of some nineteen or twenty medical societies throughout the state, endeavoring to familiarize myself with the problems of this group in the year 1940. Although at times it was difficult, because of my keeping up an active practice, I assure you that it was interesting and instructive. I shall always look back with pleasure to these experiences of meeting most delightful men and women of the profession in their homes and communities. I also attended the centennial meeting of the Illinois State Medical Society at Peoria. As you know, next year will be our centennial, and I wanted to get some ideas. During the past few months certain definite thoughts have presented themselves to me. Some are new to you; others are old friends.

One of the first subjects I wish to dwell on is the question of the hospital board of directors. It is my understanding that according to the laws of Wisconsin all corporations must be set up with officers and have regular meetings of a board of directors. These directors are to be elected by incorporators, or their successors, at stated periods. The hospitals of the state are organized as non-profit corporations, and in over 90 per cent of the institutions of this state there is no real board of directors. The superintendent suggests visiting boards acting in advisory capacities, or the charities involved do so. This is akin to a president of a corporation appointing his directors or our Secretary appointing the Council. The fact of the matter is, these boards are not elected by due process of law in accordance with the statute on corporations, and they do not meet once a month to pass on bills and declare the policies of the institution. These institutions owe it to the people of this state to correct this loose and probably illegal situation immediately. Incidentally, this would make for a better relationship between the physician and his hospital and improve the efficiency of the hospital in the eyes of the people it serves.

The next matter I wish to present to you is a closely allied one. It is that of hospital superintendents. I believe hospital superintendents should be physicians, wherever possible. When the institution is too small to have a physician–superintendent, the superintendent should be a graduate nurse. In this case, she should be under the guidance of an executive committee of physicians of the community served. All our state institutions, the State of Wisconsin General Hospital, the Milwaukee County

Hospital, the tuberculosis institutions, and Mount Sinai Hospital are headed by physician–superintendents. A hospital is an institution for the care of the sick. It should be run by a nurse or a physician, the only ones schooled in the care of the sick. The accountant and the purchasing agent should be hired and supervised by them. A physician–superintendent, particularly in these controversial times, makes for better relationship with the staff and serves the public with greater understanding.

The third point I wish to bring to your attention briefly is daylight-saving time. We will waive the fact that the great metropolitan areas to the East and South of us, and Michigan, to the North, have had it for years, and look at it entirely from a point of view of health. Historically it was defeated by labor, including former Mayor Hoan, as being a rich man's move. The movie industry said it ruined their attempts to run two paying performances. The electric trade unions felt there would be less use of lights. The labor unions, through the farm labor group, influenced the farmer, and daylight-saving was outlawed. I believe it is to the best interests of the laboring man and the health of youth to reopen this subject matter since increased exposure to the sun in this vigorous northern climate would be a definite asset. This movement cannot be furthered without support from the press and interested welfare organizations, but with their help this group might see fit jointly to sponsor such a movement.

The fourth point I wish to stress is the matter of public safety. We have progressed tremendously in the last few years, but much still remains to be done. I believe medicine should assume leadership in this regard, with every county society in this state having a live committee on public health and safety. Such a committee should be the guiding force in its community and work in harmony with the state committee.

The fifth point is that of interesting the laymen of our communities in our projects. When I was president of the Milwaukee Academy of Medicine, we had a lay board of trustees to aid in running our building, since sold to the state. One was the president of our largest department store group, the Schuster Stores—Mr. Max Friedman. Another was Harold Falk, president of the Falk Corporation. A third was Robert Friend, president of the Nordberg Manufacturing Company. These wonderful, public-spirited citizens were interested in us and our problems. They attended our meetings by the hour, giving of their valuable time eight to ten periods a year. Does this not suggest to you possibilities in some way tying in the finer elements of your cities, towns and villages with your local problems? Slightly allied to this thought, I have suggested to our Secretary that some time during the year we call a one-day meeting of boards of directors and key men of all the professions for a discussion of our common problems.

The sixth subject is that of dues. Let me read an excerpt from a letter written by Mr. Hunter, of the Hunter Machinery Company here, which I was privileged to get.

"Mr. Hunter, a workingman's son, doesn't have much chance these days. I asked him why, and he said, 'Well, you know my son, Carl, can get a job working for an electrical firm, which he has wanted to do, but they couldn't hire him unless he joined the union. He went to the union and they weren't taking in apprentices, but if he could join the union the initiation fee is approximately $265, and where is a boy, never having worked before, to get $265? And what workingman normally has that much for the privilege of letting his son work? In addition, they have to pay fairly stiff dues per quarter.' "

I am favorable to this Society's having whatever funds it needs for routine expenditures, controlled by a balanced budget. When and if a project presents itself that can be sold to this House of Delegates, or to the Council, if it cares to assume the responsibility, I think an assessment, within reasonable limitations, should then be levied.

The final matter I wish briefly to call to your attention is that of instructing delegates. The point was made at Green Bay the other night by Dr. Kelly that if you do not have confidence in your delegate, do not send him to the annual meeting. It is all right to outline your policies, but let him use his best judgment at the meeting. Many times new material presents itself which changes the whole aspect of the case. If the delegate has failed in his duty, you can have your opportunity to get after him when he returns home.

The Speaker announced that this address of the President-Elect was referred to the Committee on Reports of Officers and Standing Committees. It was moved by Dr. L. W. Peterson, Sun Prairie, seconded by Dr. E. H. Spiegelberg, Boscobel, and carried that Dr. Sproule's committee appointments (see page 1136) be approved.

Report of the Secretary

The Secretary was called upon by the Speaker for a report supplementary to that appearing in the August issue of the Journal, and commented briefly on the fact that the total membership was 2,478 as compared with 2,312 a year ago, and that since the publication of the August Journal there had been six additional deaths among physicians, three of them being members of the Society (Dr. H. J. Niebauer, Madison; Dr. F. A. Thayer, Beloit; Dr. T. J. Redelings, pioneer Marinette physician.)

In discussing the central office, the Secretary divided the work into four fields, as follows: (1) Continuing problems of medicine, such as poor relief, malpractice insurance, and health education. (2) Organizational work such as postgraduate courses and meetings of the Council and committees. (3) Contacts with public agencies, such as W. P. A., Crippled Children Division, Bureau of Industrial Hygiene, etc. (4) Continuing effort in the application of the insurance principle to the care of the sick.

In conclusion, the Secretary paid tribute to the loyalty and interest of his office staff.

The Speaker announced that this supplementary report of the Secretary was referred to the Committee on Reports of Officers and Standing Committees.

Dr. B. S. Adams of Hibbing, Minnesota, president of the Minnesota State Medical Association, was then presented to the members and gave a brief address. The Speaker also introduced Dr. B. J. Branton of Willmar, Minnesota, president-elect of the Minnesota State Medical Association, and Dr. Rock Sleyster of Wauwatosa, past-president of the American Medical Association.

The next item of business was presentation of the report of the Treasurer, Dr. Ira R. Sisk, Madison, as follows:

Treasurer's Report

(For the period January 1 to August 31, 1940)

	General Fund	Medical Defense Fund	Combined Funds
Cash on Hand, January 1, 1940	$ 3,257.23	$ 2,609.17	$ 5,866.40
Receipts			
Membership Dues	$35,739.25	$	$35,739.25
Special Assessment Dues	12,063.50		12,063.50
Interest on Investments	316.25	196.25	512.50
Exhibit Space Rentals	2,778.75		2,778.75
Graduate Center Fees	2,102.10		2,102.10
Miscellaneous Receipts	117.65		117.65
	$53,117.50	$ 196.25	$53,313.75
Total to be accounted for	$56,374.73	$ 2,805.42	$59,180.15
Disbursements			
President's Travel	$ 500.00	$	$ 500.00
Council and Committees	2,100.26		2,100.26
Books and Periodicals	228.84		228.84
Delegates to A. M. A.	401.05		401.05
Auxiliary	110.61		110.61
Secretary's Salary	5,970.00		5,970.00
Secretary's Travel Expense	860.59		860.59
Salaries of Staff	6,019.20		6,019.20
Assistant Secretary's Normal Travel	87.76		87.76
Accounting and Insurance	532.44		532.44
Social Security Taxes	433.56		433.56
Insurance on Secretary	244.50		244.50
Rent	1,200.00		1,200.00
Telephone and Telegraph	730.71		730.71
Supplies and Light	585.25		585.25
Postage and Printing	1,960.07		1,960.07
Fixtures and Upkeep	$ 460.25		$ 460.25
Miscellaneous	354.04		354.04
Legal	1,572.05		1,572.05
Special Bulletins to Members	824.72		824.72
Annual Meeting	597.93		597.93
Graduate Centers	2,511.27		2,511.27
Wisconsin Medical Journal	1,200.00		1,200.00
Legal Services, 1939	388.75		388.75
Hygeia	257.50		257.50
Press	290.15		290.15
Lay Publications	40.00		40.00
Services, General Counsel	818.16		818.16
Voluntary Sickness Insurance Trials	2,327.78		2,327.78
Investment Securities Purchased	3,130.75		3,130.75
Membership Dues Refunded	15.00		15.00
Total Disbursements	$36,753.19	none	$36,753.19
Cash on Hand, August 31, 1940	$19,621.54	$ 2,805.42	$22,426.96

Securities Owned by State Medical Society of Wisconsin, September 1, 1940

General Fund	Interest Rate	Maturity	Face Value
Dominion of Canada	2½%	8–15–45	$2,000.00
Dominion of Canada	3¼%	1–15–61	2,000.00
Pacific Telephone and Telegraph Company	3¼%	12– 1–66	1,000.00
Milwaukee Gas Light Company	4½%	3– 1–67	2,000.00
Canadian National Railway Company	5%	10– 1–69	2,000.00
Dayton Power and Light Company	3%	1– 1–70	3,000.00
Total General Fund Securities			$12,000.00
Medical Defense Fund			
Milwaukee County Metropolitan Sewerage Bond of 1925	4½%	3–18–44	$1,000.00
United States Treasury Bonds	3¼%	4–15–44 –46	2,000.00
Pennsylvania Power & Light Company	3½%	8– 1–69	2,000.00
Southern California Edison Co., Ltd.	3¾%	5– 1–60	2,000.00
Wisconsin Gas and Electric Company	3½%	4– 1–66	1,000.00
Pacific Telephone and Telegraph Co.	3¼%	12– 1–66	1,000.00
Total Medical Defense Fund Securities			$ 9,000.00
Securities on Hand, August 31, 1940			$21,000.00

The Speaker then announced his retirement as presiding officer, introducing Dr. R. M. Kurten of Racine, vice-speaker.

The report of the Treasurer was referred to the Committee on Reports of Officers and Standing Committees, as well as supplementary reports by Dr. C. A. Dawson, River Falls, for the Committee on Public Policy, and Dr. C. D. Neidhold, Appleton, for the Committee on Voluntary Sickness Insurance. Dr. E. J. Carey, chairman of the Council on Scientific Work, stated that there was no additional report from this group.

The three delegates to the American Medical Association (Dr. S. E. Gavin, Fond du Lac; Dr. J. C. Sargent, Milwaukee; Dr. J. F Smith, Wausau) presented reports which were likewise referred to the Committee on Reports of Officers and Standing Committees.

There followed a recess for district caucuses, after which the House selected the members of the Committee on Nominations, as follows:

First district—J. C. Hassall, Oconomowoc
Second district—E. D. Sorenson, Elkhorn
Third district—A. R. Tormey, Madison
Fourth district—C. A. Armstrong, Prairie du Chien
Fifth district—T. H. Rees, Manitowoc
Sixth district—P. R. Minahan, Green Bay
Seventh district—W. M. Trowbridge, Viroqua
Eighth district—A. A. Cantwell, Shawano
Ninth district—J. F. Smith, Wausau
Tenth district—C. N. Hatleberg, Chippewa Falls
Eleventh district—T. J. O'Leary, Superior
Twelfth district—L. W. Hipke, Milwaukee
Thirteenth district—W. P. Curran, Antigo

Upon motion of Dr. H. H. Christofferson, Colby, seconded by Dr. L. O. Simenstad, Osceola, and carried, these nominations were declared valid, these members to constitute the Nominating Committee.

Amendment Relative to Elections

The Speaker then asked the Secretary to read the proposed amendment to the Constitution affecting the election of Councilors after 1940, which had laid on the table for a year and now came before the House for action.

Section 2. The President, President-Elect, Speaker and Vice-Speaker shall be elected by the House of Delegates. The Secretary and Treasurer shall be elected by the Council. Councilors shall be elected at a meeting of their respective district societies held within the twelve months' period prior to the annual meeting of the State Society at which the term of Councilor expires. Certification of such election, signed by the President and Secretary of the councilor district society, shall be placed in the hands of the Secretary of the State Medical Society prior to the annual meeting of the Society in the year in which the term of such Councilor expires. In the event a councilor district fails so to certify its election, the election for Councilor of such district shall be by the House of Delegates. Notices of election of a Councilor in a district shall be incorporated in a mailed notice to the members of the district at least seven days before the meeting at which the election is to be held.

Election, where more than one nomination is received, shall be by ballot and a majority of votes cast shall be necessary to elect. Each candidate for Councilor must be a resident of the district which it is proposed to represent and no person known to have solicited votes for or sought the office of Councilor shall be eligible for the current election. Other procedure essential to the election shall be governed by Robert's Rules of Order.

The officers, except the Councilors, shall be elected annually. The terms of Councilors shall be for three years, and all officers shall serve until their successors are elected and installed. There shall be elected one Councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional Councilor for each additional 250 members or major fraction thereof. As nearly as possible, one-third of the members of the Council shall be elected each year.

The President-Elect shall automatically succeed the office of President at the conclusion of his one-year term of President-Elect.

Discussion was presented by the following: Dr. J. F. Smith, Wausau; Dr. E. H. Spiegelberg, Boscobel; Dr. H. H. Christofferson, Colby; Dr. T. J. O'Leary, Superior; Dr. A. E. Rector, Appleton; Dr. L. W. Peterson, Sun Prairie; Dr. D. J. Twohig, Fond du Lac; Dr. J. W. Boren, Marinette. The Speaker then called for the vote, and upon roll call all delegates, except one, voted in the negative.

Resolution Relative to Military Service

Dr. R. E. Fitzgerald, Milwaukee, as chairman of the M-Day Committee, introduced the following resolution, which was referred to the Committee on Resolutions:

WHEREAS, Our national government has found it expedient to conscript all men between the ages of twenty-one and thirty-five; and

WHEREAS, Cognizant of the existing emergency and in full accord with our government, and realizing that the sacrifices of all mobilized men will necessarily extend into the economic field; and

WHEREAS, A great number of the members of our profession will unquestionably be inducted into service; be it

Resolved, That we as members of the State Medical Society of Wisconsin in a spirit of patriotic duty, here and now give to each colleague who may be conscripted or who may volunteer, our solemn assurance that we will do everything within our power to protect his practice and preserve it for him during his absence from the community.

Amendment Relative to Dues

Dr. L. W. Peterson, Sun Prairie, introduced amendments to the Constitution and By-Laws by the Dane County Medical Society. These amendments, which read as follows, must lay on the table for one year and be published twice in that interval in the Wisconsin Medical Journal:

Amend the Constitution by numbering the present contents of Article X as Section 1 and creating Section 2 of Article X to read:

The House of Delegates, by adoption of a By-Law, may provide for a special classification of members at per capita reduced dues. Such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

Amend Chapter VIII of the By-laws by creating Section 4, to read:

Physicians and graduates, training as hospital residents or as research fellows, may be admitted to membership in the county society upon payment of dues not to exceed twelve dollars ($12) yearly, of which at least six dollars ($6) shall be remitted to the State Society.

Amendment Relative to Hospital Practice

Dr. M. C. Rosekrans, Neillsville, introduced an amendment, which was referred to the Committee on Amendments to the Constitution and By-Laws:

WHEREAS, The Special Committee to Study the Distribution of Health Service and Sickness Care in Wisconsin, in its report to the State Medical Society in 1938, adopted by the House of Delegates, said:

"The committee recommends that the extent of privileges of physicians in general hospitals, assuming that their practices are not such as contravene the public interest, be determined on the basis of their individual abilities;"

WHEREAS, This recommendation can be followed effectively only by amendment of the By-laws of the State Medical Society;

Now, therefore, be it resolved, That Chapter XI be amended by renumbering Sections 8, 9, and 10, to be Sections 9, 10, and 11, respectively, and a new Section 8 be inserted in Chapter XI, to read as follows:

"Hospitals are recognized as institutions in which medicine is practiced, and not as institutions which practice medicine. Any hospital organized as an eleemosynary institution which is the only available institution within a given area should erect no barrier against, and, on the contrary, should extend staff privileges to those licensed to practice medicine and surgery on the basis of their individual abilities, assuming that their individual practices are not such as contravene the public interest. Each county society shall have the responsibility to, and at the direction of the Council shall, accomplish the purpose and effect of this By-law."

Resolution Relative to Associated Hospital Service

Dr. R. G. Arveson, Frederic, President, introduced a letter and resolution from Associated Hospital Service, Inc., as follows:

Dr. R. G. Arveson,
Frederic, Wisconsin.

Dear Dr. Arveson: The board of directors of Associated Hospital Service, Inc., has directed me to send you the enclosed resolution which was passed at a special meeting held at eight p. m., on September 9, 1940.

The board will be pleased to have you present this resolution to your delegate body at the proper time.

May I, at the same time, be permitted to express my sincere best wishes to you for a successful and profitable session.

Very truly yours,
JOSEPH G. NORBY.

WHEREAS, Associated Hospital Service, Inc., a non-profit hospital service corporation, was organized under the provisions of enabling legislation, sponsored by the Wisconsin Hospital Association, the Wisconsin Conference of the Catholic Hospital Association of the United States and Canada, and the Medical Society of the State of Wisconsin to contribute to the solution of a pressing social and economic problem of payment for hospital services by low income groups; and

WHEREAS, The members and directors of Associated Hospital Service, Inc., consist of non-medical persons designated, three each, by participating hospitals, two of whom are directors of or active in the operation of the participating hospital, and physicians and surgeons, one for each participating hospital, appointed by the medical staff of the hospital, and approved by the Medical Society of the State of Wisconsin; and

WHEREAS, It is desirable that Associated Hospital Service, Inc., operated solely for the public interest, have the approval of the Medical Society of the State of Wisconsin, along with the approval of the American Hospital Association, the Wisconsin Hospital Association, the Wisconsin Conference of Catholic Hospitals of the United States and Canada, and of the public, which it has long since enjoyed; therefore, be it

Resolved, By the board of directors of Associated Hospital Service, Inc., that the Medical Society of Wisconsin, now assembled, be invited to express and record its approval of the Associated Hospital Service, Inc. by appropriate action, so that the public may be further assured that it will contribute to the solution of the social problem of payment for hospital services of the low income groups, and merit the continued support of the citizens of the state for whose interest said legislation was sponsored and Associated Hospital Service, Inc., was organized; be it further

Resolved, That Associated Hospital Service, Inc., extends its cordial greetings to the Medical Society of the State of Wisconsin.

(Signed) JOSEPH G. NORBY, *President*,
L. R. WHEELER, *Executive Secretary*.

Discussion was presented by the following: Dr. R. G. Arveson, Frederic; Dr. A. H. Heidner, West Bend; Dr. C. A. Armstrong, Prairie du Chien. It was moved by Dr. Armstrong, seconded by Dr. J. G. Hoffmann, Hartford, and carried that this resolution be laid on the table.

Upon motion of Dr. W. D. Stovall, Milwaukee, and seconded by Dr. Irwin Schulz, Milwaukee, the House adjourned at 11:05 p. m. until Wednesday at 8:00 p. m.

WEDNESDAY EVENING SESSION

The House reconvened in a continuation of the recessed executive session at 8:15 p. m., Wednesday evening, September 18, 1940, in the Auditorium of Marquette University School of Medicine, Speaker R. M. Kurten presiding. The Secretary declared a quorum present.

Dr. Irwin Schulz, Milwaukee, chairman of the Committee on Officers and Standing Committees, presented the committee's recommendation that the following reports published in the August Journal and supplemented at the Tuesday session, be ac-

cepted: Committee on Cancer, Advisory Committee on Crippled Children, Committee on Goiter, Committee on Health and Public Instruction, Committee on Mental Hygiene and Institutional Care, Committee on Maternal and Child Welfare, Committee on Tuberculosis and Chest Diseases, Committee on Safety on Public Highways, Centennial Committee, Treasurer's Report, and Secretary's Report. This motion was seconded by Dr. A. R. Tormey, Madison, and carried.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. R. G. Baker, Tomahawk, the report of the Council on Scientific Work as published in the August Journal, was adopted.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. C. A. Armstrong, Prairie du Chien, the report of the Conference Committee on Open Panels as published in the August Journal, was adopted.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. P. R. Minahan, Green Bay, the report of the Committee on Public Policy as published in the August Journal and as supplemented by Dr. C. A. Dawson at the Tuesday session, was adopted.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. L. W. Peterson, Sun Prairie, the House accepted the suggestions of President R. G. Arveson that (1) a statement be printed setting forth the educational requirements and length of time necessary for completion of courses in medicine and the cults, to be distributed among the medical profession, (2) physicians take greater interest in political affairs, and (3) the subject of postgraduate instruction be referred to the Council on Scientific Work.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. C. D. Neidhold, Appleton, the House accepted the committee's recommendation concerning two additional points in President Arveson's address, that is, that the subjects of reregistration of physicians and appointment of physicians to the State Board of Medical Examiners be referred to a committee for study.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. H. M. Caldwell, Columbus, the House accepted the report of President-Elect Sproule, with the recommendation that the matters mentioned therein be taken up by present committees.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. E. H. Spiegelberg, Boscobel, the report of the Committee on Industrial Health published in the August Journal, supplemented at the Tuesday session, was accepted, with the recommendation of the committee that an investigation be made to see whether financial assistance for this program could be obtained from the Industrial Commission or the State Board of Health, and that the activities be correlated with those of the Committee on Open Panels.

In view of the voluminous nature of the report of the Advisory Committee on Voluntary Sickness Insurance, both as published in the August Journal and as supplemented, Dr. Schulz, for the Committee on Reports of Officers and Standing Committees, presented the various recommendations separately with a motion for approval:

1. That an appropriate press release which had been prepared be given to the newspapers (seconded by Dr. M. C. Rosekrans, Neillsville; carried).

2. That a Special Committee on Voluntary Sickness Insurance be appointed by the incoming President (seconded by Dr. E. D. Sorenson, Elkhorn; carried).

3. That the Council be directed to include in the 1941 budget the sum of $2,000 for further study and experimentation in voluntary sickness insurance (seconded by Dr. George Parke, Viola; carried).

4. That on the question of discontinuing the trial plans in both Douglas and Milwaukee Counties (recommended by the Advisory Committee on Voluntary Sickness insurance), the State Society withhold a definite decision until the respective county societies had had an opportunity to act. After extensive discussion by Dr. T. J. O'Leary, Superior, it was moved by Dr. J. F. Smith, Wausau (seconded by Dr. H. O. McMahon, Milwaukee, and carried) to amend the recommendation to the effect that if Douglas County desired to continue experiments in the matter of health insurance, the State Society give them the benefit of such studies as have been made, but that after January 1 no further financial subsidy or support be given. The recommendation by Dr. Schulz, for the committee, to withhold a definite decision, with qualifications as stated, was seconded by Dr. Louis Fauerbach, Madison, and carried.

5. That the House of Delegates express their concern over the great implications of the entry of commercial insurance companies into the field of voluntary sickness insurance, and urge that close relationships be developed with the companies by the American Medical Association. Also that extensive continuation of the study of voluntary sickness insurance by commercial insurance companies be further pursued by the State Society (seconded by Dr. H. M. Caldwell, Columbus; carried).

6. That no prepaid medical care plan or voluntary sickness insurance agency of the State Medical Society or any of its component county medical societies delegate to others the responsibility of sales of subscriber contracts, solicitation of subscribers, or accounting procedures (seconded by Dr. J. F. Smith, Wausau; carried).

7. That further experimentation engaged in by members of the Society shall be conducted by the State Society only, and shall be so designed as to be possible of state-wide application (seconded by Dr. G. W. Ison, Crandon; carried).

Discussion on the report of the Advisory Committee on Voluntary Sickness Insurance was presented by Dr. R. W. Blumenthal, Milwaukee; Dr. H. O.

McMahon, Milwaukee; Dr. C. D. Neidhold, Appleton; Dr. J. F. Smith, Wausau; Dr. T. J. O'Leary, Superior; and Dr. Charles Fidler, Milwaukee.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. C. D. Neidhold, Appleton, the report of the Committee on Reports of Officers and Standing Committees was adopted in its entirety.

Dr. J. W. Boren, Marinette, chairman of the Committee on Amendments to the Constitution and By-Laws, in presenting his report made motions for adoption of the following amendments to the By-Laws:

Amendment Relative to Appeals to Council

Amend Section 3, Chapter VI of the By-Laws by striking the words "from the decision of an individual councilor" (seconded by Dr. A. G. Hough, Beaver Dam; carried).

Amendment Relative to Optional Method of Election of Members

Amend Section 3, Chapter XI of the By-Laws by striking the period, inserting a semicolon, and adding the following: "or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society" (seconded by Dr. A. R. Tormey, Madison; carried).

Amendment Relative to Establishment of Scientific Sections

Amend the By-Laws by renumbering the present Chapter XII to be Chapter XIII, inserting a new Chapter XII to be entitled "Scientific Sessions" to read as follows:

Section 1. The House of Delegates shall, from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

Section 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

Section 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

Section 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

Section 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved (seconded by Dr. A. G. Koehler, Milwaukee; carried).

Amendment Relative to Eligibility for Membership

Amend Section 3, Chapter XI of the By-Laws by adding the italicized words and repealing the word "to" in the sentence that follows: "Every reputable and legally qualified physician who is a citizen of the United States and who is a bona fide resident of the same county shall be eligible *to apply for* (to) membership so long as . . . " (seconded by Dr. H. H. Christofferson, Colby; carried).

Amendment Relative to Status of Member After Removing From Territorial Limits of County Society

Amend the By-Laws by adding the following to Section 3, Chapter XI, of the By-Laws:

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed (seconded by Dr. L. W. Hipke, Milwaukee; carried).

Amendment Relative to Extension of Hospital Staff Privileges

Amend Chapter XI of the By-Laws by renumbering Sections 8, 9, and 10, to be Sections 9, 10, and 11, respectively, and adding a new Section 8 to read as follows:

Hospitals are recognized as institutions in which medicine is practiced, and not as institutions which practice medicine. Any hospital organized as an eleemosynary institution which is the only available institution within a given area should erect no barrier against, and on the contrary, should extend staff privileges to those licensed to practice medicine and surgery on the basis of their individual abilities, assuming that their individual practices are not such as contravene the public interest. Each county society shall have the responsibility to, and at the direction of the Council shall, accomplish the purpose and effect of this by-law.

After discussion by Dr. C. A. Armstrong, Prairie du Chien; Dr. Charles Fidler, Milwaukee; Dr. M. C. Rosekrans, Neillsville; Dr. H. O. McMahon, Milwaukee; and Dr. O. A. Stiennon, Green Bay, it was moved by Dr. Fidler, seconded by Dr. J. C. Griffith, Milwaukee, and carried that this amendment be tabled for discussion Thursday morning.

The meeting adjourned at 9:50 p. m. to reconvene at 8:00 a. m. the following day.

THURSDAY MORNING SESSION

The House reconvened at 8:05 a. m., Thursday, September 19, 1940, in a continuation of the recessed executive session, Speaker R. M. Kurten presiding.

Amendment Relative to Extension of Hospital Staff Privileges

The Secretary restated the amendment, introduced by Dr. R. C. Rosekrans, Neillsville, relative to the extension of hospital staff privileges which was laid on the table at the Wednesday session. Discussion was presented by Dr. C. A. Armstrong, Prairie du Chien; Dr. W. A. Olson, Greenwood; Dr. A. G. Hough, Beaver Dam; Dr. J. W. Prentice, Ashland; Dr. H. H. Christofferson, Colby; Dr. J. F. Smith, Wausau. An amendment by Dr. C. J. Weber, Sheboygan (seconded by Dr. C. R. Kwapy, Oconto), that a committee of three study this problem and report back to the House next year was defeated. The question then before the House was an amendment by Dr. H. O. McMahon, Milwaukee, that the By-Law and all matters pertaining thereto be referred to the Council for study and subsequent report to the House. Upon acceptance of this amendment, the Secretary, at the suggestion of Dr. Hough, announced that any member could record his views on this subject with the Council.

Upon motion by Dr. J. F. Smith, Wausau, seconded by Dr. E. H. Spiegelberg, Boscobel, the report of the Committee on Amendments to the Constitution and By-Laws was accepted, with the amendment as stated.

Committee on Report of the Council

In presenting the report of the Committee on Report of the Council, Dr. K. H. Doege, Marshfield, chairman, reaffirmed the principles expressed and approved the Council's action, with the following recommendation: "This committee recommends that the specialists engaged in medical service in hospitals be encouraged to discontinue all contracts with hospitals, contracts not consistent with the concept of the American Medical Association and State Medical Society of Wisconsin on the practice of medicine in and by hospitals, to the end that the position of organized medicine be not embarrassed or jeopardized by the principle of usage which might eventually establish their activities as a form of hospital practice, thereby encouraging a principle which would be detrimental to the public."

An amendment presented by Dr. A. E. Rector, Appleton, seconded by Dr. C. J. Weber, Sheboygan, to the effect that the Secretary, either by registered letter or in person, communicate the Society's position to those members who now hold contracts, was approved. Discussion was presented by Dr. W. D. Stovall, Madison, and the secretary.

Upon motion of Dr. Doege, seconded by Dr. M. C. Rosekrans, Neillsville, the committee's amendment to the report of the Council was adopted, and subsequently upon motion of Dr. Doege, seconded by Dr. A. A. Beck, Wautoma, the report as amended was adopted.

Amendment Relative to Delegates From Scientific Sections

The Secretary gave notice that the Council felt that scientific sections should each have a delegate in the House, stating that an amendment is proposed to that effect, which will lay on the table and be voted on a year hence, after being given due publicity in the Journal.

Committee on Resolutions

Dr. W. D. Stovall, Madison, chairman of the Committee on Resolutions, moved that the following three resolutions be adopted:

WHEREAS, Our national government has found it expedient to register all men between the ages of 21 and 35, and

WHEREAS, Cognizant of the existing emergency and in full accord with our government, and realizing that the sacrifices of all mobilized men will necessarily extend into the economic field, and

WHEREAS, A great number of the members of our profession will unquestionably be inducted into service; be it

Resolved, That we as members of the State Medical Society of Wisconsin in a spirit of patriotic duty, here and now give to each colleague who may be conscripted or who may volunteer, our solemn assurance that we will do everything within our power to protect his practice and preserve it for him during his absence from the community.—Presented by Dr. R. E. Fitzgerald, chairman, M-Day Committee (seconded by Dr. J. F. Smith, Wausau; carried).

WHEREAS, Osteopathic practice is not defined and its limitations in Therapy specifically stated, and

WHEREAS, The practice of Osteopathy has encroached on the practice of medicine by the promiscuous use and abuse of therapeutic agents relegated by law to the exclusive use of practitioners of medicine, and

WHEREAS, Osteopaths neither receive training in the use of drugs in Therapeutics, nor pass a State Board in such subjects as chemistry and pharmacology, and

WHEREAS, The philosophy of their art of healing is that of a drugless one, and

WHEREAS, Through their use of the title of Doctor without indicating Osteopathy, the public is not supplied with information concerning their method of practice, and

WHEREAS, It is obvious that an opportunity for him to masquerade as a Doctor of Medicine is created, and

WHEREAS, This may result in his practicing in hospitals under false pretense,

Be it resolved, That the Committee on public policy be instructed to study and prepare methods which will define the practice of Osteopathy, specifically stating its field of practice and its limitations, and indicate the necessity of designating Doctor of Osteopathy on all signs and announcements, and

Be it further resolved, That whatever legislative action seems advisable be taken by the State of Wisconsin Medical Society.—Presented by Racine County Medical Society (seconded by Dr. T. C. Hemmingsen, Racine; carried).

Discussion on this resolution was presented by Dr. J. F. Smith, Wausau; Dr. A. G. Hough, Beaver Dam; Dr. H. J. Gramling, Milwaukee; Dr. E. H. Spiegelberg, Boscobel; Speaker Kurten, and Secretary Crownhart.

After careful consideration of the needs of the State Medical Society for the coming year, it is apparent that more funds will be required to carry on the activities of the Society. We must expect the absence of a number of members because of military service. The centennial celebration this year will require the expenditure of more than is necessary for an ordinary annual meeting. The program of the Committee on Industrial Health has been approved and its execution will require additional money. The program of the Committee on Public Policy has also been approved and will require additional funds.

Therefore, the Committee on Resolutions recommends to the House of Delegates that a special assessment of $10, in addition to the regular fee of $15, be assessed for the year 1941 (seconded by Dr. C. J. Weber, Sheboygan; carried)

Discussion was presented by Dr. O. A. Stiennon, Green Bay; Dr. Stovall, and Secretary Crownhart.

New Business

The following resolution proposed by the delegates from Rock and Wood Counties (Dr. W. A. Munn, Janesville, and Dr. K. H. Doege, Marshfield), seconded by Dr. J. S. Dougherty, Suring, was adopted:

WHEREAS, The educational requirements for entrance into nursing are becoming higher year after year, and

WHEREAS, Many of these requirements are not essential for the nursing care of patients, regardless of their desirability as a cultural background, and

WHEREAS, The amount of education acts as a basis for the increased cost of nursing for patients, and

WHEREAS, This increased cost works a great hardship on many patients, and in fact, deprives the service of a nurse from the less well-to-do, and

WHEREAS, As only nurses having the educational requirements specified by the American Association for Registered Nurses can be employed in recognized hospitals, and

WHEREAS, There is a great need for nurses whose training has emphasized the vocational rather than the more cultural phase of their training,

Therefore, be it resolved, That a committee be appointed to make a study of this problem and report to the House of Delegates what further action should be taken.

A motion made by Dr. A. G. Hough, Beaver Dam, and seconded by Dr. E. H. Spiegelberg, Boscobel, to the effect that the House meet at a time separate from the annual meeting of the State Medical Society, was lost.

A motion was made by Dr. W. D. Stovall, seconded by Dr. Louis Fauerbach, Madison, that the Secretary prepare a memorial to be presented to Dr. J. Newton Sisk, Madison, in appreciation of his service as Speaker of the House before ill health necessitated his retirement from that office. Carried.

Upon motion of the Speaker, seconded by Dr. W. D. Stovall, Madison, the House adjourned its second session, preparatory to entering immediately its third session.

THIRD SESSION

The third session of the House of Delegates convened at 9:25 a. m., Thursday, September 19, 1940, Speaker Kurten presiding. The Secretary read the report of the Committee on Credentials, and a quorum was declared present.

Election of Officers

Dr. T. J. O'Leary, Superior, chairman, presented the report of the Committee on Nominations, as follows: President-Elect, Dr. Gunnar Gundersen, La Crosse; Speaker of the House, Dr. R. M. Kurten, Racine, to succeed Dr. J. Newton Sisk, whose term expired; Vice-Speaker of the House, Dr. Charles Fidler, Milwaukee, to succeed Dr. R. M. Kurten, whose term expired; Delegates to the American Medical Association, Dr. S. E. Gavin, Fond du Lac, to succeed himself, and Dr. J. C. Sargent, Milwaukee, to succeed himself; Alternate Delegate to the American Medical Association, Dr. S. J. Seeger, Milwaukee, to succeed himself; Alternate Delegate to the American Medical Association, Dr. F. E. Butler, Menomonie, to succeed Dr. A. S. White, whose term expired.

Upon motion by Dr. Stovall, seconded by Dr. C. D. Neidhold, Appleton, the report of the Nominating Committee was adopted. The Secretary announced that each nomination would be acted on separately to permit of additional nominations from the floor, and in each instance the Secretary was instructed to cast a unanimous ballot for the nominee.

1941 Meeting in Madison

Upon motion of President Arveson, seconded by Dr. L. W. Peterson, Sun Prairie, Madison was established as the meeting place in 1941.

Introduction of President-Elect Gundersen

Dr. Gunnar Gundersen, La Crosse, was escorted to the chair, and addressed the House briefly.

Dr. A. S. Jackson, Centennial Chairman

Dr. R. P. Sproule, Milwaukee, incoming president, announced the appointment of Dr. A. S. Jackson, Madison, as general centennial chairman.

Election of Councilors

Upon motion of Dr. L. W. Peterson, Sun Prairie, seconded by Dr. Louis Fauerbach, Madison, Dr. W. T. Clark of Janesville was named as councilor for the third district to succeed himself.

Upon motion of Dr. C. A. Armstrong, Prairie du Chien, seconded by Dr. George Parke, Viola, Dr. B. I. Pippin of Richland Center was named as councilor for the fourth district to succeed himself.

Upon motion of Dr. C. J. Weber, Sheboygan, seconded by Dr. J. G. Hoffmann, Hartford, Dr. A. H. Heidner, of West Bend was named as councilor for the fifth district to succeed himself.

Upon motion of Dr. A. G. Koehler, Oshkosh, seconded by Dr. P. R. Minahan, Green Bay, Dr. S. E. Gavin of Fond du Lac was named as councilor for the sixth district to succeed himself.

Upon motion of Dr. Charles Fidler, Milwaukee, seconded by Dr. J. C. Griffith, Milwaukee, Dr. R. W. Blumenthal of Milwaukee was named as councilor to succeed himself.

In discussing the subject of specialist practice in hospitals, Dr. A. E. Rector, Appleton, made the motion, seconded by Dr. J. W. Prentice, Ashland, and carried, that a committee be appointed by the Speaker to cooperate with the specialists in dealing with this important subject. Discussion was presented by Dr. W. A. Munn, Janesville; Dr. J. W. Prentice, Ashland; Dr. A. E. Rector, Appleton; Dr. Charles Fidler, Milwaukee; Dr. C. J. Weber, Sheboygan; Dr. J. G. Hoffmann, Hartford; Speaker Kurten, and Secretary Crownhart.

Upon motion by Dr. L. W. Peterson, Sun Prairie, seconded by Dr. Gunnar Gundersen, La Crosse, it was decided that the House request the Council to work out way and means of honoring members who have a long record of membership, with some token of esteem and recognition.

There being no further business, on motion of Dr. L. W. Peterson, Sun Prairie, seconded by Dr. C. D. Neidhold, Appleton, the House adjourned at 10:15 a. m., sine die.

Attendance at House of Delegates, Milwaukee, 1940

Society	*Delegate*	*Sessions* 1	2	3
Ashland–Bayfield–Iron	J. W. Prentice, Ashland	a	x	x
	C. J. Smiles, Ashland*	x	x	x
Barron–Washburn–Sawyer–Burnett	A. S. White, Rice Lake	a	a	a
	R. W. Adams, Chetek*	x	x	x
Brown–Kewaunee–Door	P. R. Minahan, Green Bay	x	x	x
	W. W. Kelly, Green Bay*	a	a	a
	O. A. Stiennon, Green Bay	x	x	x
	W. E. Leaper, Green Bay*	a	a	a
Calumet	F. P. Knauf, Kiel	a	x	x
	J. W. Goggins, Chilton*	a	a	a
Chippewa	C. N. B. Hatleberg, Chippewa Falls	x	x	x
	A. J. Somers, Chippewa Falls*	a	a	a
Clark	M. C. Rosekrans, Neillsville	x	x	x
	B. H. Dike, Owen*	a	a	a
Columbia–Marquette–Adams	H. E. Gillette, Pardeeville	a	x	a
	H. M. Caldwell, Columbus*	x	x	x
Crawford	C. A. Armstrong, Prairie du Chien	x	x	x
	E. T. Ackerman, Gays Mills*	a	a	a
Dane	L. W. Peterson, Sun Prairie	x	x	x
	N. A. Hill, Madison*	a	x	x
	Louis Fauerbach, Madison	x	x	x
	F. L. Weston, Madison*	a	a	a
	W. D. Stovall, Madison	x	x	x
	A. T. Smedal, Stoughton*	a	a	a
	A. R. Tormey, Madison	x	x	x
	S. A. McCormick, Madison*	a	x	a
Dodge	A. G. Hough, Beaver Dam	x	x	x
	F. T. Clark, Waupun*	x	x	a
Douglas	T. J. O'Leary, Superior	x	x	x
	Charles W. Giesen, Superior*	a	a	a
Eau Claire–Dunn–Pepin	S. L. Henke, Eau Claire	x	x	x
	B. F. Johnson, Mondovi*	a	a	a
Fond du Lac	D. J. Twohig, Fond du Lac	x	x	x
	J. C. Devine, Fond du Lac*	x	x	a
Forest	G. W. Ison, Crandon	x	x	x
	E. G. Ovitz, Laona*	a	a	a
Grant	E. H. Spiegelberg, Boscobel	x	x	x
	J. D. Glynn, Lancaster*	x	x	a
Green	L. E. Creasy, Monroe	x	x	x
	J. H. Bristow, Monroe*	a	a	a
Green Lake–Waushara	A. A. Beck, Wautoma	x	x	x
	L. J. Seward, Berlin*	a	x	x
Iowa	S. B. Marshall, Hollandale	a	a	a
Jefferson	W. S. Waite, Watertown	x	x	x
	G. E. Eck, Lake Mills*	a	x	x
Juneau	C. A. Vogel, Elroy	a	a	a
	A. R. Kaufman, Mauston*	a	a	a
Kenosha	G. C. Schulte, Kenosha	x	x	x
	W. C. Stewart, Kenosha*	a	a	a
La Crosse	A. H. Gundersen, La Crosse	x	x	x
	E. E. Gallagher, La Crosse*	x	x	x
Lafayette	R. B. Quinn, Darlington	a	a	a
Langlade	W. P. Curran, Antigo	x	x	a
	C. E. Zellmer, Antigo*	x	a	a
Lincoln	F. C. Lane, Merrill	a	a	a
	R. G. Baker, Tomahawk*	x	x	x
Manitowoc	E. C. Cary, Reedsville	a	a	a
	T. H. Rees, Manitowoc*	x	x	x
Marathon	J. F. Smith, Wausau	x	x	x
	E. E. Flemming, Wausau*	a	a	a

Society	Delegate	Sessions 1	2	3
Marinette–Florence	J. W. Boren, Marinette	x	x	x
	A. T. Nadeau, Marinette*	a	x	x
Milwaukee	J. O. Dieterle, Milwaukee	x	x	x
	B. J. Birk, Milwaukee*	a	a	a
	C. W. Eberbach, Milwaukee	x	x	a
	E. A. Brzezinski, Milwaukee*	x	x	x
	Charles Fidler, Milwaukee	x	x	x
	S. J. Darling, Milwaukee*	a	a	a
	R. E. Galasinski, Milwaukee	x	x	x
	G. S. Flaherty, South Milwaukee*	x	a	a
	J. L. Garvey, Milwaukee	x	x	x
	P. J. Niland, Milwaukee*	x	x	x
	L. W. Hipke, Milwaukee	x	x	x
	P. E. Oberbreckling, Milwaukee*	x	x	x
	Irwin Schulz, Milwaukee	x	x	a
	E. D. Schwade, Milwaukee*	x	x	a
	L. M. Wieder, Milwaukee	x	x	a
	C. M. Schoen, Milwaukee*	x	x	x
	J. C. Griffith, Milwaukee	x	x	x
	R. A. Toepfer, West Allis*	a	a	a
	A. R. Langjahr, Milwaukee	x	x	x
	Bernard Krueger, Cudahy*	x	x	a
	H. O. McMahon, Milwaukee	x	a	a
	D. F. Pierce, Hales Corners*	x	x	a
	J. W. Smith, Milwaukee	x	x	x
	W. J. Scollard, Milwaukee*	x	x	x
	W. F. Grotjan, Milwaukee	x	x	x
	S. E. Biller, Milwaukee*	a	x	x
Monroe	A. R. Bell, Tomah	a	a	a
	G. C. Devine, Ontario*	x	x	x
Oconto	J. S. Dougherty, Suring	a	x	x
	C. R. Kwapy, Oconto*	a	x	x
Oneida–Vilas	W. S. Bump, Rhinelander	x	x	x
	I. E. Schiek, Rhinelander*	a	a	a
Outagamie	C. D. Neidhold, Appleton	x	x	x
	D. M. Gallaher, Appleton*	x	a	a
Pierce–St. Croix	A. E. McMahon, Glenwood City	a	a	a
	O. H. Anderson, Plum City*	a	a	a
	C. A. Dawson, River Falls (appointed alternate)	x	x	a
Polk	L. O. Simenstad, Osceola	x	x	x
	W. B. Cornwall, Amery*	a	a	a
Portage	A. G. Dunn, Stevens Point	x	x	x
	M. G. Rice, Stevens Point*	a	a	a
Price–Taylor	J. D. Leahy, Park Falls	x	x	x
	H. B. Norviel, Phillips*	a	a	a
Racine	R. M. Kurten, Racine	x	x	x
	T. C. Hemmingsen, Racine*	x	x	x
Richland	W. C. Edwards, Richland Center	a	a	a
	George Parke, Viola*	x	x	x
Rock	W. A. Munn, Janesville	x	x	x
	W. T. Clark, Janesville*	x	x	x
	H. E. Kasten, Beloit	x	x	x
	H. A. Raube, Beloit*	a	a	a
Rusk	L. M. Lundmark, Ladysmith	a	a	a
	W. F. O'Connor, Ladysmith*	a	a	a
Sauk	A. C. Edwards, Baraboo	x	x	x
	M. F. Huth, Baraboo*	x	x	x
Shawano	A. A. Cantwell, Shawano	x	x	x
	F. L. Litzen, Gresham*	a	a	a
Sheboygan	C. J. Weber, Sheboygan	x	x	x
	A. C. Radloff, Plymouth*	a	x	a
Trempealeau–Jackson–Buffalo	R. L. Alvarez, Galesville	a	a	a
	M. O. Bachhuber, Alma*	a	a	a
Vernon	W. M. Trowbridge, Viroqua	x	x	x
	W. H. Remer, Chaseburg*	a	a	a
Walworth	E. D. Sorenson, Elkhorn	x	x	a
	C. J. Brady, Lake Geneva*	a	a	a
Washington–Ozaukee	J. G. Hoffmann, Hartford	x	x	x
	O. J. Hurth, Cedarburg*	x	x	a
Waukesha	J. C. Hassall, Oconomowoc	x	x	x
	R. E. Davies, Waukesha*	x	x	x
Waupaca	J. H. Murphy, Clintonville	x	x	a
	R. K. Irvine, Manawa*	a	x	x
Winnebago	A. G. Koehler, Oshkosh	x	x	x
	J. P. Canavan, Neenah*	a	x	a
Wood	K. H. Doege, Marshfield	x	x	x
	F. X. Pomainville, Wisconsin Rapids*	a	a	a

*—Alternate delegate.
x—Present.
a—Absent.

"CONTINUATION COURSES" IN MINNESOTA

The University of Minnesota announces its January schedule of continuation hospital and medical courses as follows:

January 2–4. Problems of Executive Housekeepers (for representatives of hotels, hospitals and institutions).

January 20–25. Ophthalmology (for ophthalmologists and otolaryngologists).

January 27–February 1. Hospital Administration.

For further information see the January issue of The Journal or write to: Dr. William A. O'Brien, University of Minnesota, Minneapolis.

Medical Opportunities in a Small Urban Community*

By WARNER S. BUMP, M. D.
Rhinelander

The first installment of Dr. Bump's article appeared in the November, 1940, issue of The Journal, pp. 975–980.

IF IT is difficult to be a great physician, it is easy to be a mediocre one. The opportunity today is not for such; but for the alert, thoughtful practitioner who feels his responsibility, and who, through constant observation, reading, and study, develops clear habits of thought and action.

I have said that to be such a practitioner and to continue as one is a difficult task, probably the most difficult in all the medical fields. But in spite of this, it is interesting to note that long periods of training in hospitals and laboratories do not furnish the way to competency as a general practitioner. In the special fields of medicine in which manual dexterity, mastery of technical details, and familiarity with the use of special instruments are necessary before even beginning practice, varying periods of assistanceship are quite necessary. It is exceedingly difficult for a surgeon worthy of the name to become accomplished enough to handle well all lesions he might encounter in the abdomen, for instance, in less than five years of diligent study under a master surgeon. There is no such royal road for the general practitioner.

As Dr. Rufus Cole recently said, "There is such a thing as the technic of practice and this technic you cannot learn in the University Medical School," and I might add, or the hospital, or the laboratory. The technic and skill of practice, Dr. Cole rightly insists, can be acquired only by practice itself simultaneous with hard, unremitting study and labor.

Many times the prolongation of the young graduate's hospital and laboratory experience in positions of little responsibility has brought to my mind the classical picture of the son born to a wealthy family. Theoretically this son has every opportunity. Heredity, education, and material resources are all in his favor. Yet he fails to achieve because the necessity of taking on responsibility is usually lacking. In this same way, too long a stay in the hospital and laboratory may be an actual hindrance to the student who desires to become a general practitioner; for the final responsibility concerning the patient's diagnosis and actual treatment is seldom placed on him alone. As a result he does not come to feel the necessity to investigate with despatch or judge for himself and act quickly. These qualities are essential to the general practitioner and must be developed early by acceptance of full responsibility in actual practice.

As I look back upon my medical education, one period of training stands out as the most valuable of all. This was the special service in pathology under Dr. Edwin Raymond Le Count. In addition to his regular classes Dr. Le Count selected one student each quarter for special work. During a period of about two years each of us in this service stepped forward every three months, the man behind us taking over our duties, while we took over the tasks of the man ahead. This work progressively led from the careful bacteriological examination of fluids obtained at many autopsies; to the descriptions of hundreds of brains; to six or more months in the Cook County Morgue where four to twelve or more bodies were examined every day; and finally to the position of instructor in charge of the classroom. And never during these two years did Dr. Le Count lecture or teach in the common sense of these words. Never did we receive so-called "spoon-feeding." He placed responsibility squarely upon our shoulders. "Before coming to me," he said, "you have studied the fundamentals of pathology. Here is a great abundance of material. Use it and learn through your own efforts. Observe ac-

* Paper read before a University of Wisconsin Medical School convocation, November 23, 1939.

curately and record concisely what you see. Then study and determine the meaning of the data you record. I shall not rob you of the joy of discovery; but I shall tell you of your mistakes."

This experience taught me in a most forceful manner that, after all, the best instructor is one's own self, provided that he has cultivated the ability to observe, to think, and to use libraries and thus learn what others have thought. Regardless of how little actual knowledge the graduate in medicine takes with him upon graduation, if he has learned these things, his schooling has been, indeed, successful.

General practice is much like that experience under Dr. Le Count. The formal medical education and internship furnish the fundamentals and the tools for actual work.

When the graduate physician starts to practice, responsibility is thrust upon him. His patients, his own patients not those of some one else, furnish increasing responsibilities and increasingly abundant material for study. His success or failure as a physician depends upon how he takes advantage of this material.

Please do not think that the opportunity is not really there; for it is, not only to become a good and useful member of the profession, but also to become a great physician whose work may benefit not only your generation, but the generations after you. I think of Dr. Meltzer who, according to Rufus Cole, for many years drove about with a horse and buggy tending to his general practice, spending what time he could in his laboratory. During this time he made contributions to medicine and physiology of such importance that upon the founding of the Rockefeller Institute he was invited to work there. He died one of the most productive students of disease that our country has had.

I think of Sir James Mackenzie who, after serving one year in the Edinburgh Royal Infirmary, settled down to practice in Burnley, a little town in Lancashire. His work on the heart, which was the most important in the generation and which revolutionized all concepts of cardiac disease, was carried out not in fine large hospitals or university clinics, but in the rounds of his busy general practice in a small community. Nor had Mackenzie spent years of apprenticeship to prepare him for his great adventure. But he had trained himself to observe and he took time to observe and to ponder what he saw. Let me quote from the writings of this man who truly touched greatness:

"The time is approaching when, in the course of nature, I must fall out of the ranks, and before doing so I wish to look back upon my medical career to see what light my experience may throw upon medical science. The life of the general practitioner is not considered one that can help much in the advance of medicine. * * * You know well that if a man aspires to research work, it is to the laboratories or to the hospital wards he is sent. As a result of my experience, I take a very different view, and assert with confidence that medicine will make but halting progress, while whole fields essential to the progress of medicine will remain unexplored, until the general practitioner takes his place as an investigator. The reason for this is that he has opportunities which no other worker possesses—opportunities which are necessary to the solution of problems essential to the advance of medicine. * * * He has the opportunity to investigate the early stages of disease. * * * He has the opportunity to understand the changes effected by disease in its progress, to acquire a knowledge of the life-history of disease from start to finish. It is this watching of individuals during the whole course of disease which is the only basis for an intelligent prognosis. * * * No doubt * * * in the laboratories and in the wards of hospitals * * * observations of utmost importance are made; but what opportunities have these investigators of seeing disease in its early stages and during its progress. In the wards of the hospital, as you know, disease is not presented in its early stages; the opportunity of watching its progress is limited to the short time the patient spends in the hospital. The vast majority of persons, when they first perceive that there is something amiss, turn to their family doctor and continue under his care. It is the general practitioner, who sees dis-

ease in its early stages, who has the opportunity of finding out what condition predisposed to the disease and of following it through all its stages. * * * If the signs of the past had been read aright, this would have been recognized long ago. If any of you seek to inquire how the efficacy of vaccination was discovered, you will at once be brought to realize that Jenner might have spent his entire lifetime in laboratories and hospital wards and yet never have made his discovery; simply because he would never have had the opportunity. * * * I have heard it repeatedly stated by leading members of our profession that the limits of clinical medicine have been reached, and that no further progress can be made until new methods have been discovered. This belief is widespread, and we see its effect in the sudden rush which is made after any new mechanical device. Now I want to impress upon you the fact that the means of investigation which we possess in ourselves without the use of mechanical devices, have not yet even been begun to be employed on a scientific basis. Exact methods are now widely recognized as necessary in investigations, and as their recognition is the outcome of laboratory practice, laboratory methods have at present a dominating influence in medical research. But as yet we scarcely perceive the limitations of laboratory methods. You can readily understand that in the discovery of the mechanism of some obscure process laboratory experiments are essential; but to find out what bearing that obscure process has upon your patient's future life is quite another matter. Nevertheless, it is a matter essential for you to know. It follows, then, that research in clinical medicine must pursue lines of its own; these lines are not the loose, speculative ones of bygone days, but the precise and accurate observations on living individuals by means of which alone knowledge of real value can be obtained."

I have quoted Dr. Mackenzie at length because his words are as true now as they were when he wrote them and well do they tell you that the general practitioner in the small community need not merely apply the knowledge unearthed by others; but that he has the opportunity to be a vital force himself in adding to the store of useful medical knowledge.

Unquestionably, almost everywhere, there are great opportunities for competent students in all the fields of medical science, in research or in actual practice. And undoubtedly some of you, because of special gifts or even because of certain limitations, should continue to fit yourselves for some special service in the broad field of medical science. But the whole thesis of my discussion with you today is, first, the indication of, what I consider, the greatest need in medical practice and, secondly, the portrayal of the kind of man to satisfy that need.

In summary then, I may say that that need, especially in small communities, is for general practitioners of medicine; physicians who are imbued with the idea of serving and at the same time educating their patients; physicians who with the honesty of a Fenger are critical of their every habit of thought and every act; physicians who realize that they are the advisers of the people who seek their aid and that they are the means through which any or all the vast resources of medicine may be mobilized to furnish that aid; physicians who are aware that their actual education is obtained not in the classroom, or hospital, or laboratory, but through their own continuous study and effort simultaneous with and in conjunction with the experiences of actual practice; and finally physicians who realize their potential position as leaders, as architects in the building of sounder and more efficient methods of preventing, recognizing, and curing disease, architects who see the work in its entirety and who are not hesitant to delegate portions of the great task to others specializing in restricted fields; continually bearing in mind that old motto, "Truth in the science, morality in the art."

The place of the medical profession in the program of national defense and the medical mobilization of Canada are among the topics to be discussed at the Thirty-Seventh Annual Congress of the Council on Medical Education and Hospitals of the American Medical Association, to be held at the Palmer House, Chicago, February 17 and 18, *The Journal* of the Association reports in its December 7 issue.

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THE JOURNAL BOOKSHELF

BOOKS RECEIVED FOR REVIEW

Obstetrics in General Practice. By J. P. Greenhill, B. S., M. D., F. A. C. S., professor of obstetrics and gynecology, Loyola University Medical School, Chicago; professor of gynecology, Cook County Graduate School of Medicine, etc. Cloth. Price, $3.50. Pp. 448, illustrated. Chicago: The Year Book Publishers, 1940.

Treatment of Diabetes Mellitus. By Elliott P. Joslin, A. M., M. D., Sc. D., medical director, George F. Baker Clinic, New England Deaconess Hospital; clinical professor of medicine emeritus, Harvard Medical School; consulting physician, Boston City Hospital. With Howard F. Root, M. D., instructor in medicine, Harvard Medical School; Priscilla White, M. D., instructor in pediatrics, Tufts College Medical School; and Alexander Marble, M. D., instructor in medicine, Harvard Medical School. Ed. 7, enlarged and thoroughly revised. Cloth. Price, $7.50. Pp. 783, illustrated. Philadelphia: Lea and Febiger, 1940.

Colwell's Daily Log for Physicians, 1941. An account book for physicians. Champaign, Ill.: Colwell Publishing Company, 1940.

A Treatise on Medicolegal Ophthalmology. By Albert C. Snell, M. D., lecturer in ophthalmology, School of Medicine and Dentistry, University of Rochester; consultant in ophthalmology, Strong Memorial Hospital, and Rochester General Hospital; ophthalmologist, Park Avenue Hospital, Rochester, New York; member of the American Ophthalmological Society; Fellow of the American College of Surgeons, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology. Cloth. Price, $6. Pp. 312, illustrated. St. Louis: The C. V. Mosby Company, 1940.

Taber's Cyclopedic Medical Dictionary. By Clarence Wilbur Taber, author, *Taber's Dictionary for Nurses*, etc., and associates. Cloth. Price, thumb-indexed, $3, plain, $2.50. Pp. 111, with 273 illustrations. Philadelphia: F. A. Davis Company, 1940.

Diseases Affecting the Vulva. By Elizabeth Hunt, B. A., M. D., Ch. B. (Liverp.), honorary physician to the skin department, South London Hospital for Women; honorary dermatologist, New Sussex Hospital for Women and Children, Brighton; temporary honorary dermatologist, Royal Infirmary, Liverpool; formerly senior medical officer, Radium Institute and Hospital for Skin and Cancer Diseases, Liverpool. Cloth. Price, $4. Pp. 215, with 36 illustrations and 18 plates in colour. St. Louis: The C. V. Mosby Company, 1940.

The 1940 Year Book of General Medicine. Edited by George F. Dick, M. D., J. Burns Amberson, Jr., M. D., George R. Minot, M. D., S. D., F. R. C. P. (Edinburgh and London), William B. Castle, M. D., A. M., M. D. (Hon.) Utrecht, William D. Stroud, M. D., George B. Eusterman, M. D. Cloth. Price, $3. Pp. 934, illustrated. Chicago: The Year Book Publishers, 1940.

Fractures and Dislocations for Practitioners. By Edwin O. Geckeler, M. D., Fellow of the American College of Surgeons, Fellow of the American Academy of Orthopaedic Surgeons, Diplomate of the American Board of Orthopaedic Surgery. Cloth. Price, $4. Pp. 314, illustrated. Baltimore: The Williams & Wilkins Company, 1940.

The 1940 Year Book of Pathology and Immunology. Edited by Howard T. Karsner, M. D., professor of pathology, director of the Institute of Pathology, Western Reserve University, Cleveland; and Sanford B. Hooker, A. M., M. D., professor of Immunology, Boston University School of Medicine; member, Evans Memorial for Clinical Research and Preventive Medicine; immunologist, Massachusetts Memorial Hospital. Cloth. Price, $3. Pp. 650, with 100 illustrations. Chicago: The Year Book Publishers, 1940.

The 1940 Year Book of Industrial and Orthopedic Surgery. Edited by Charles F. Painter, M. D., orthopedic surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. Cloth. Price, $3. Pp. 450, with 150 illustrations. Chicago: The Year Book Publishers, 1940.

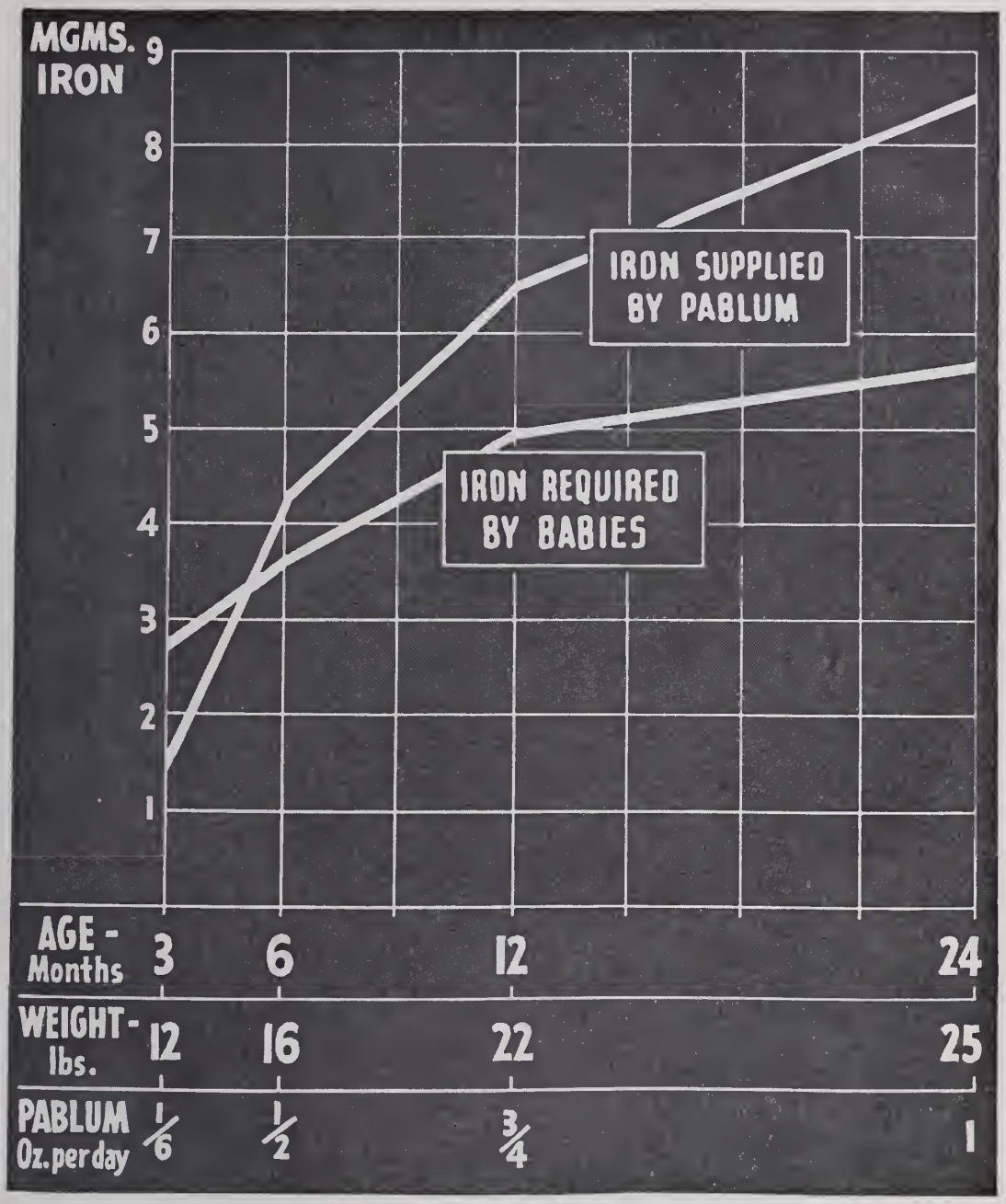
BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

The Diagnosis and Treatment of Cardiovascular Disease. Edited by William D. Stroud, B. S., M. D., F. A. C. P., professor of cardiology, University of Pennsylvania Graduate School of Medicine. 2 volumes. Cloth. Price, $18. Pp. 1743, with nearly 400 illustrations and 3 full-page color plates. Philadelphia: F. A. Davis Company, 1940.

In the compilation of this extremely comprehensive two-volume treatise on cardiovascular disease, Dr. Stroud has enlisted the services of the outstanding authorities in the field. The list of contributors comprises fifty-six specialists, most of whom have long been known for their special knowledge of, and contributions to, the particular subjects presented by them. For example, the chapter on Congenital Heart Disease was written by the late Maude Abbott, one chapter on Rheumatic Fever by T. Duckett Jones, Chronic Constrictive Pericarditis by Paul D. White, Electrocardiography by Frank Wilson and Bellet and McMillan, Coronary Disease by Fred M. Smith, Robert Levy and William Stroud, Surgery of the Heart by Claude S. Beck, and Deficiency Diseases and Their Effect on the Heart by Soma Weiss. The subject of Thromboangiitis Obliterans was covered by Leo Buerger, Varicose Veins by Geza de Takats, and several chapters on other phases of peripheral vascular disease were contributed by Edgar V. Allen.

Each of the various etiologic types of heart disease has been systematically discussed. Treatment has been stressed and representative case histories have



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been presented for practical illustrations. In addition, special chapters have been devoted to valvular disease, cardiac dilatation and hypertrophy, congestive heart failure, paroxysmal cardiac dyspnea, edema and other symptom complexes with which the practitioner is frequently confronted. This multiple approach has unavoidably resulted in a considerable amount of overlapping by some of the authors, but this may be considered an advantage as the reader thus has been afforded more than one viewpoint.

The discussions of the heart in hyperthyroidism, in pulmonary disease, in renal disease, in diseases of the glands of internal secretion and in anemia are excellent. For those interested in the industrial phase of heart disease the chapters on "Trauma of the Heart" and "The Cardiac in Industry" will be found of distinct value. The cardiac arrhythmias and their treatment have been dealt with in detail. H. M. Marvin has written an excellent chapter on "The Prevention and Relief of Heart Disease as a Public Health Problem", and has included a most interesting history of the origin and development of the American Heart Association, its purposes and aims. However, it did appear to the reviewer that Dr. Marvin expressed an unduly pessimistic attitude toward the potential beneficial results which might be expected from organizing the treatment of active rheumatic heart disease along the same general lines which have proved so effective in controlling pulmonary tuberculosis. The last two paragraphs on p. 1027, which are too long to quote here, contain a number of statements which seem decidedly open to question.

The section on electrocardiography is well organized and contains a large number of tracings representative of practically all of the various types and patterns encountered clinically.

An entire chapter has been devoted to "Total Thyroidectomy in Chronic Heart Disease", and a number of readers will be surprised to find that ablation of the thyroid is still being advocated in certain cases of myocardial failure and coronary insufficiency. Rather rigid criteria have been set up for the selection of cases and a strict pre- and postoperative regime has been outlined in the light of past experience.

The subject of hypertension has been given careful consideration. The chapter entitled "Psychic Factors in Essential Arterial Hypertension" is particularly well done and should be read by every practitioner of medicine. The chapter presenting the more general considerations of "Hypertensive Arterial Disease" was written by Dr. E. J. Stieglitz. The material has been well presented, but the reviewer feels compelled to take issue with the author on the question of medicinal measures. The author still advises the use of bismuth subnitrate as the drug of choice for securing generalized vasodilatation. He first recommended this form of therapy in 1928, and in the meantime many internists have given the method a thorough trial, but so far as the reviewer has been able to ascertain, few, if any, have succeeded in duplicating Stieglitz's results. On the other hand, potassium sulphocyanate is dismissed with one case history describing an unfavorable result obtained in a woman of 71. After the blood cyanate had risen very rapidly to 11.1 mg. per 100 cc. on a dose of 10 grains per day, the dose was increased to 15 grains a day and 48 hours later, with a sudden rise of blood cyanate to 18.2 mg. per 100 cc., the patient became irrational and developed a skin rash. Such a reaction might have been anticipated in a woman of this age and could easily have been avoided had the principles outlined by Barker been followed. It is this type of abuse of thiocyanate which has retarded its development and prevented its acceptance by the medical profession in a field where Barker and others have shown that it can be and its being administered safely and with distinctly beneficial results to a large group of patients suffering from essential hypertension.

Practical discussions of the cardiac patient as a surgical or obstetrical risk have been included. Wolforth and Margoles have presented an excellent chapter on heart sounds and their recording by graphic methods. All in all, Dr. Stroud is to be congratulated on having assembled such a brilliant array of authors whose contributions, together with his own, have resulted in a valuable reference work on both cardiac and vascular diseases. It is up to the minute, easy to read, covers the entire field in a most practical manner and can be highly recommended not only to the general practitioner and the internist, but to the surgeon, the obstetrician and the pediatrician as well. C. M. K.

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Synopsis of Materia Medica, Toxicology, and Pharmacology, for Students and Practitioners of Medicine. By Forrest Ramon Davison, B. A., M. Sc., Ph. D., M. B., assistant professor of pharmacology in the School of Medicine, University of Arkansas, Little Rock. Cloth. Price, $5. Pp. 633 with 45 illustrations, including 4 in color. St. Louis: The C. V. Mosby Company, 1940.

This handbook is correctly titled a synopsis and may serve a useful purpose for the beginner in the field of pharmacology or therapeutics, similar to *Useful Drugs*. The avowed purpose of the author to present only drugs of proven therapeutic worth has been reasonably well accomplished although the information is too meager to suffice for a clear approach to therapy. Condensation of such a vast material as is included in the scope of this volume must lead inevitably to dogmatic statements, many of which are hardly consistent with fact or reason; for example, "Paraldehyde is an ideal hypnotic since it is a mild heart stimulant," and again, "Arecoline, which causes stimulation of peristalsis, may be used as an antidote for mushroom poisoning of the muscarine type." In the opinion of the reviewer the volume is insufficiently annotated to serve as a useful text. M. H. S.

Methods for Diagnostic Bacteriology. By Isabelle G. Schaub, A. B., assistant in bacteriology, department of pathology and bacteriology, The Johns Hopkins University School of Medicine and M. Kathleen Foley, A. B., bacteriologist in charge of the diagnostic bacteriological laboratory of the medical clinic, Johns Hopkins Hospital, Baltimore. Cloth. Price, $3. Pp. 313. St. Louis: The C. V. Mosby Company, 1940.

The authors have assembled and presented in working sequence the procedures which they have found successful in the routine bacteriologic diagnosis of clinical and autopsy material. Their instructions for handling each source material on the basis of its source, organism suspected and contingent possibilities are admirably calculated to minimize failure in obtaining initial growth and isolation of cultivable pathogenic bacteria. The bacteriologic and serologic tests directed for the subsequent identification take into account the recent developments in bacteriology and immunology and should promote competent bacteriologic practice.

The diagnosis of syphilis, the identification of the animal parasites of man, the determination of the blood groups—frequently devolving upon the bacteriologist—are not considered in this volume: warrantable omissions on the basis of definition and the tendency toward laboratory specialization. F. E. H.

Modern Dermatology and Syphilology. By S. William Becker, M. D., associate professor of dermatology and syphilology, Kuppenheimer Foundation, University of Chicago, and Maximillian E. Obermayer, M. D., assistant professor of dermatology and syphilology, Kuppenheimer Foundation, University of Chicago. Cloth. Price, $12. Pp. 871, with 461 illustrations in the text and 32 full color plates. Philadelphia: J. B. Lippincott Company, 1940.

This is a very attractive volume of nearly 900 pages which was written for medical students and those medical practitioners who have but a forced interest in the diagnosis and treatment of skin diseases. There are several things about this book which make it distinctly different from other works and which should appeal to those students and practitioners. Perhaps the outstanding feature is the replacement of the old rubber-stamp type of description with a modernized variety. Another is the insertion of a preliminary note labeled "Orientation" with each of the thirty-six chapters on dermatological topics. These explanatory prologues serve to give the reader a proper background for the descriptions which follow and in each instance are most valuable. In the portrayal of the several disease entities and syndromes the authors have emphasized that they are putting forward the results of their therapeutic experiences at the University of Chicago Clinics. Moreover, they have used an easy lecture style of writing in preference to the more staid encyclopedic style. The net result of all of these is a very valuable addition to dermatologic literature.

The book is well published with good photographs and charts. The last twenty-one chapters on syphilology are written in the same fashion as are those on dermatology. The "modern" theme prevails throughout. R. L. M.

The Practice of Medicine. By Jonathan Campbell Meakins, M. D., LL. D., professor of medicine and director of the department of medicine, McGill University; physician-in-chief, Royal Victoria Hospital, Montreal; formerly professor of therapeutics and clinical medicine, University of Edinburgh. Ed. 3. Cloth. Price, $10. Pp. 1430 with 562 illustrations including 48 in color, St. Louis: The C. V. Mosby Company, 1940.

This is certainly one of the better textbooks of medicine. It includes many of the physiological and chemical explanations of disease and emphasizes disturbances in function in contrast to those of morphology, especially terminal morphology. It is deficient as are so many textbooks of internal medicine in its discussion of personality problems which play such an important role in the understanding of the patient as a unit. C. F. M.

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